Fall 2013

Opinions of Individuals in the Greater Durban Area Concerning Government Healthcare

Alexander Braun
SIT Study Abroad

OPINIONS OF INDIVIDUALS IN THE GREATER DURBAN AREA CONCERNING GOVERNMENT HEALTHCARE

Keywords: Public Administration, Health Care Management, Public Health, Economics

	MY ISP MAY NOT BE PUBLISHED OR QUOTED IN ANY WAY – STRICTLY CONFIDENTIAL – VIEWED BY OTHER DURBAN SIT HEALTH STUDENTS ONLY
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO INCLUDE MY ISP IN ITS PERMANENT LIBRARY COLLECTION.
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO RELEASE MY ISP IN ANY FORMAT TO INDIVIDUALS, ORGANIZATIONS, OR LIBRARIES IN THE HOST COUNTRY FOR EDUCATIONAL PURPOSES AS DETERMINED BY SIT.
X	I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO PUBLISH MY ISP ON ITS WEBSITES AND IN ANY OF ITS DIGITAL/ELECTRONIC COLLECTIONS, AND TO REPRODUCE AND TRANSMIT MY ISP ELECTRONICALLY. I UNDERSTAND THAT WORLD LEARNING'S WEBSITES AND DIGITAL COLLECTIONS ARE PUBLICLY AVAILABLE VIA THE INTERNET. I AGREE THAT WORLD LEARNING IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED USE OF MY ISP BY ANY THIRD PARTY WHO MIGHT ACCESS IT ON THE INTERNET OR OTHERWISE.

Alexander Braun

November 30, 2013

SIT Study Abroad – Durban Community health

Fall 2013

Advisor: Keith Wimble

Abstract

One important determinant of health in South Africa is how government entities, from the local level to the national level, use their health budgets. A complex system of organizations involving many government employees at the various levels are involved in the process of turning a budget allocation of Rand into healthcare services and goods that make their way to the South African people. What do individuals in the greater Durban area think about that process as it exists currently, and what do they think of the services that are eventually delivered to them? This is an important question, especially in a new democracy facing significant health challenges.

To begin answering this question, the researcher developed nine survey questions that were posed to a total of 35 individuals, including both experts and non-experts, through personal interviews. The data from these interviews was then analyzed for patterns in an attempt to determine if current government healthcare spending strategies align with the priorities and interests of the people that the government is supposed to serve. As a whole, participants were in disagreement about the current quality of government healthcare spending, but thought that it has improved in the recent past and will improve in the near future. Three main issues arose, including the lack of investment in preventative care, the lack of investment in training health professionals, and poor management. The NHI was strongly supported by all participants who knew of its existence and appears to be a system worth the difficulty of its installation.

Acknowledgments

I would like to thank Clive for overseeing this project. I would like to thank him for coming up with my topic, and for encouraging and aiding me in its early stages and planning. I would also like to thank my advisor, Keith Wimble, for helping me hit the ground running by providing valuable insights about the government healthcare system. Thanks to all the participants who took time out of their days to allow me to interview them. Without them, this project would not exist. I would like to give a special thanks to the expert participants, who were very responsive to my inquiries, showing genuine interest in my project and helping me to learn a tremendous amount about my topic. Lastly, I would like to thank Zed, Thula, and Hlobi for handling all the logistics and complications that come with organizing 16 independent study projects. We are all enormously thankful for your help and support.

Table of Contents

Introduction

The overarching goal of this research project is to gain a better understanding of the relationship between government healthcare spending plans and the desires of individuals in the greater Durban area concerning government healthcare expenditure. Within this framework, this project will present an accurate description of the current government healthcare budget spending plans at the national, provincial (KwaZulu-Natal), and district (eThekwini) levels[1]. Through interviews, the researcher has attempted to gain an understanding of the opinions and knowledge of both experts and non-experts in the greater Durban area concerning governmental healthcare spending at these levels. The gathered data has been analyzed in both a qualitative and quantitative manner in an attempt to find the presence or absence of agreement within and between interview groups. The researcher attempted to answer the following questions in the course of this research:

1. How is the government spending its healthcare budget at each level: National, Provincial, and district?
2. With which aspects of government healthcare spending are the participants familiar?
3. What are the opinions of experts and non-experts concerning the spending with which they were familiar?
4. What do participants think about the current course of government healthcare spending, and how would they change that course if they could?
5. Is there consensus among experts in regard to the above questions?
6. Is there consensus among non-experts?
7. Is there consensus among experts and non-experts?
8. Is there consensus among demographic groups such as race and gender?
9. Is there a feasible healthcare spending plan that would appease some or all of the participants?
10. Where does the new National Health Insurance (NHI) plan fit into this discussion?

[1] The facility level was left out due to the wide variety of situations within different healthcare facilities along with the inability to focus on one facility in expert interviews. Therefore, a comparison between facilities' reported budget spending and expert opinion would have been extremely difficult. Experts were still asked about the facility level and their responses are presented in the Findings/Analysis section.

The researcher followed a survey methodology for data collection. Each participant was interviewed using a standardized survey with slight variation for experts and non-experts. The survey questions were crafted with the goal of gaining an understanding of the above questions as well as each participant's view of the health system as a whole. The responses to the survey questions were then examined quantitatively and qualitatively in order to gain an understanding of the relationships among the simplified answers as well as among the rationales for those answer.

Much of the published literature about South African government healthcare spending accessible on the Internet involves expert research on healthcare problems of the country or of a specific area within South Africa. For example, a study by Tollman et al. (2008) looked at causes of death in South Africa in 2002-2005. The researchers compared this data to similar studies conducted in 1992-1994 to determine changes in causes of death, in order to identify growing health issues. While this quantitative data is valuable, it does not engage South African citizens in an effort to prioritize their opinions. Of the studies that did engage participants, most were guided, targeting one specific health problem such as obesity (Puoane et al. 2012). Several studies discussed below directly interpreted the opinions of the population concerning healthcare using old data gathered through the 1994 South Africa National Household Survey of Health Inequalities (Hirschowitz, R. et al. 1995). Another study used the 1998 Kaiser National Household Survey on health inequalities in South Africa to examine patient satisfaction (Myburgh et al. 2005). One source in the more recent past, a household survey and subsequent report conducted by the South African Department of Health initiated in 2003, examined patient satisfaction directly. However, this study also focused primarily on gathering quantitative data about existing health problems and healthcare utilization rather than on polling the desires of the people regarding the future of South African healthcare (South African Demographic and Health Survey, 2007). It thus appears that there is a dearth of data, especially current data, on peoples' opinions of government healthcare expenditure. This study, although small in size, helps answer questions that few have directly asked in the South African context.

Why is answering this question important? When deciding how to spend money in a health system on which so many citizens rely, it is important that the voices and opinions of the beneficiaries of government health programs are heard. The Declaration of Alma-Ata (1978) states, "The people have the right and duty to participate individually and collectively in the

planning and implementation of their health care". Similarly, the Ottawa charter (21 November 1986) promotes the strengthening of community action, saying that "health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavors and destinies". More recently, at the Third International Conference on Health Promotion held in Sundsvall, Sweden (9-15 June 1991), one of the four key public health action strategies identified was "enabling communities and individuals to take control over their health…".

While the concept of community involvement is presented vaguely in these documents, a logical component of such involvement is community influence on the allocation of the government healthcare budget. Given the relative youth of democracy in South Africa, it is especially important that citizens be given this control. As stated by Coovadia et al. 2009, "the will of the people, expressed through…mobilisation against failed policies in democracies, is the best investment for a healthy future" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Experts, however, must also be involved in the planning of government healthcare expenditure, as they theoretically have the knowledge and experience required to achieve the most efficient and productive results. To understand the extent to which the citizens of KwaZulu-Natal both are, and feel as though they are, in control of the healthcare provided to them, they must be asked. This study will provide a glimpse of the opinions of citizens in the greater Durban area on this matter. If enough of these opinions are gathered, government officials and experts will have a better idea of how to spend the government healthcare budget in the best interest of the people they serve.

Frequently used acronyms and technical terms

PCH – Primary healthcare

NHI – National Health Insurance

ARV – Anti-retroviral

ART – Anti-retroviral treatment

KZN – KwaZulu-Natal

Methodologies:

1. Design:

Research in this study followed a survey methodology. The researcher administered a standardized survey in an interview format in order to determine the opinions of individuals about government healthcare spending. Responses to these interview questions were then compared to each other as well as to secondary research in an attempt to answer the research questions. The survey was a cross-sectional survey in which each participant was interviewed only once. Interview responses were then compared to determine if patterns existed. A combination of qualitative and quantitative analysis was used to shed light on similarities and differences between interview responses. Personal interviews, as opposed to questionnaires or other less intimate forms of contact, provided the best chance of collecting comprehensive and accurate data on the desired subject. For example, responses to some questions led to follow-up or clarifying questions that cannot be prepared ahead of time. Also, the researcher did not have enough time to sufficiently pilot questions for a larger scale written response survey. Quantitative analysis was used to categorize answers. For example, answers to the question 'on what should the government spend its healthcare budget?' were categorized quantitatively based on the primary spending suggestions given by each interviewee. Qualitative analysis was used to interpret the passion and emotional content of each answer as well as the logical integrity of each answer. Overall, this research was exploratory in nature, attempting to find answers to posed questions without a desired outcome.

2. Sampling Plan:

The primary method of sampling used in this study was surveys intended to determine the opinions of participants about government healthcare spending. These surveys were administered via personal interview. The researcher attempted to interview as diverse a group of experts as possible, although the ability to do that was limited due to dependency upon the connections made through SIT and the researcher's advisor, as well as by the availability of the contacted experts. This targeted convenience sampling strategy was successful, producing enough interviews that significant snowball sampling was unnecessary. Overall, 6 experts, with varying areas of expertise, were interviewed. This allowed a better understanding the process through which budget plans are determined, shedding light on who makes decisions at each of the government levels in question. More generally, experts had unique and informed views about healthcare spending and are an interesting bridge between government officials and the general population.

The second interview group was non-experts. The researcher interviewed a relatively diverse group of South African non-experts for this category[2]. The researcher conducted several interviews using contacts in Cato Manor (a Durban township) made through a one-month homestay experience. The researcher accumulated the majority of interview through cold interviewing at public parks and libraries in the Durban City Center and Chatsworth areas. Through this strategy, the researcher conducted a sufficient number of interviews. Some diversity was achieved among interviewees. However, the interviews gathered from libraries most likely biased the sample towards more educated and younger participants. The researcher interviewed each of the participants personally, using a translator recruited from the local population when necessary. Translators were only necessary for two participants, with the translator being a child of the participant in both cases.

The researcher was able to collect a total of 29 non-expert interviews and 6 expert interviews. Any individual willing to participate was included within the non-expert group with the exception of those under the age of 18. Some demographic information was recorded for each participant, including years of education, race, and gender, although no specific assortment of these characteristics was pursued. Only those who had a related college level degree or higher or those who have related field experience were considered experts. All experts had at least one

[2] Demographic information for all participants can be found in appendix 2

postgraduate degree either in a health or policy field and several had first hand experience within the government healthcare system or in government policy-making positions. The same demographic information was recorded for experts, again with no specific assortment characteristics being pursued. Although a relatively diverse group of individuals from the greater Durban area was interviewed, the small sample size caused by time and transportation constraints guarantees that some opinions and demographic groups were missed.

The goal of this sampling plan was to interview as many participants as possible. The greater the number of participants, the greater the likelihood of capturing an accurate representation of the opinions of those in the Durban area. While interviewing participants with whom the interviewer had a pre-existing relationship was valuable, cold interviewing in parks and libraries was the most productive as participants had the time, and were willing, to be interviewed. Given budget, transportation, and time constraints, the ability to walk to and from these public locations allowed for the most efficient use of time and appeared to be the best strategy for gathering a large volume of interviews. In contrast, the difficulty getting to and from the Cato Manner and Chatsworth sites originally targeted for snowball sampling greatly limited the total number of trips to those areas, causing the researcher to focus more heavily on cold interview methodology.

3. Data Collection

Two different populations were interviewed in the course of this project, experts and non-experts. In order to find the answers to the questions stated in the introduction (objectives) section, the researcher created a 9-question survey that was followed for all participants[3]. A tenth question was asked only of expert participants. For several questions, experts were also asked to provide unique responses for the three levels of government reviewed in this study. During interviews, the researcher asked every question on the survey, using note taking to document responses. The note taking consisted of writing down the general concepts of the participant's answer to each question. Expert interviews were also recorded via portable microphone due to the large volume if information. The researcher then referred to the recordings of expert interviews for the specifics of each answer as well as for direct quotations. Hand-written notes were found to be sufficient for non-expert interviews and thus voice

[3] Survey can be found in appendix 1

recording was not used. The researcher was able to take notes in a relaxed style for both expert and non-expert interviews, letting the researcher's focus fall mainly on the participant during the interview. This allowed each participant to remain comfortable as well as allowing the researcher to think of clarifying and follow-up questions when necessary. Significant follow-up questions asked of experts were noted and stated in the sections below where necessary. The only additional questions asked of non-expert participants were for clarification of a survey question. The researcher kept one specific notebook with all interview notes and the audio recordings were saved on the researcher's personal computer. This data collection method was logical for this project because survey sampling was the best available method for collecting viewpoints about government healthcare spending within budget and time constraints. Through interviews, rather than written surveys, the researcher was able to collect both the qualitative and quantitative data in the depth required to answer the proposed research questions.

4. Data Analysis:

After data was collected, it was examined in both a quantitative and qualitative manner. All questions were summarized and analyzed using Microsoft Excel. A graph or table was created and included below where appropriate. In this way, patterns among answers were analyzed and presented. Each question was first examined individually for patterns within the two main participant groups, experts and non-experts. The researcher then looked for significant patterns in responses between experts and non-experts and between different demographic groups. The demographic groups examined were race and gender. The qualitative answers from questions asking for explanations of opinions are presented through quotations as much as possible. In this way, the emotion and lived experience of those interviewed is presented along with the summarized quantitative data. In this way, a full and rich picture of the group of participants and their views is displayed.

Findings and Analysis

Socio-historical context:

"After 15 years, South Africa is still grappling with the legacy of apartheid and the challenges of transforming institutions and promoting equity in development" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). While progress has been made, the South African

government is still far from the objectives set out in the constitution of equality and the right to health: "after democracy, the country is still grappling with massive health inequities. There are marked differences in rates of disease and mortality between races, which reflect racial differences in the access to basic household living conditions and other determinants of health" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

To address this issue, the ANC, which has been the dominant political party since the beginning of democracy through the most recent elections, decided to create a healthcare system based on "the concept of primary health care as promoted at Alma Ata and envisioned a system based on community health centers. Primary health care, delivered via a district health system, was made the cornerstone of health policy" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). With this new organization, the three level system of governance that remains in control of healthcare to this day was established. The three levels are the national level, the provincial level, and the district level. Initially, the districts wielded substantial power. However, "in the National Health Act, passed in 2004, both the district health system and primary health care were defined as provincial responsibilities; this definition centralised power with the provinces" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Currently, the National Department of Health controls health policy for the country as a whole, while the 9 provincial departments and many district departments are supposed to focus on public health service delivery, including hospitals, clinics, and preventative and promotive care (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

Recently, the national government has put forward a program that would drastically change the organization of government healthcare. This program is called National Health Insurance (NHI). According to the Health Systems Trust the national minister of health, Dr Aaron Motsoaledi, was quoted as saying "The cornerstone of the proposed system of NHI is universal coverage. It is a financing system that will ensure the provision of essential healthcare to all citizens of South Africa, regardless of their employment status and ability to make a direct monetary contribution to the NHI fund" (Health Systems Trust, 2012). One of the primary focuses of the NHI in the near future is to raise the standards of government facilities so that they can be integrated seamlessly into the NHI system, which will also include currently private health facilities (Health Systems Trust, 2012). The minister of health "emphasised that the NHI will not abolish private medical health schemes and private health care providers. Instead,

government will work in cooperation with them. This will help in instances where hospitals are too far from the people. If there is a private doctor operating around the area, the department will sign a contract with the practitioner to administer NHI so primary health care can be provided to those in need" (Health Systems Trust, 2012). The government plans to phase in the NHI over the course of the next 14 years and has earmarked R1 billion to pilot projects in the 2012/13 fiscal year (Southafrica.info, 2012).

What the government is trying to do:

National level:

The South African national government states on its website that it has four overarching goals in the healthcare sector. They are: first, "increasing life expectancy", second, "decreasing maternal and child mortality", third, "combating HIV and AIDS and decreasing the burden of tuberculosis (TB)", and fourth, "strengthening health-system effectiveness" (South African Department of Health, 2012). The district health barometer (2010/11) provides general information on the spending of the government healthcare budget in national, provincial, and district contexts. "The proportion of expenditure on human resources has increased to around 59% of expenditure, while pharmaceuticals comprise the next largest proportion at 12.3%, and blood supplies, clinical supplies and laboratory costs comprise 7.1%" (Day et al. 2011, p. 21). Figure 1 shows an overview of public sector health expenditure focusing on PHC (Primary Health Care) in 2010/11 (Day et al. 2011, p. 1). Figure 2 provides a more specific description of the items on which the healthcare budget is spent.

Figure 1.

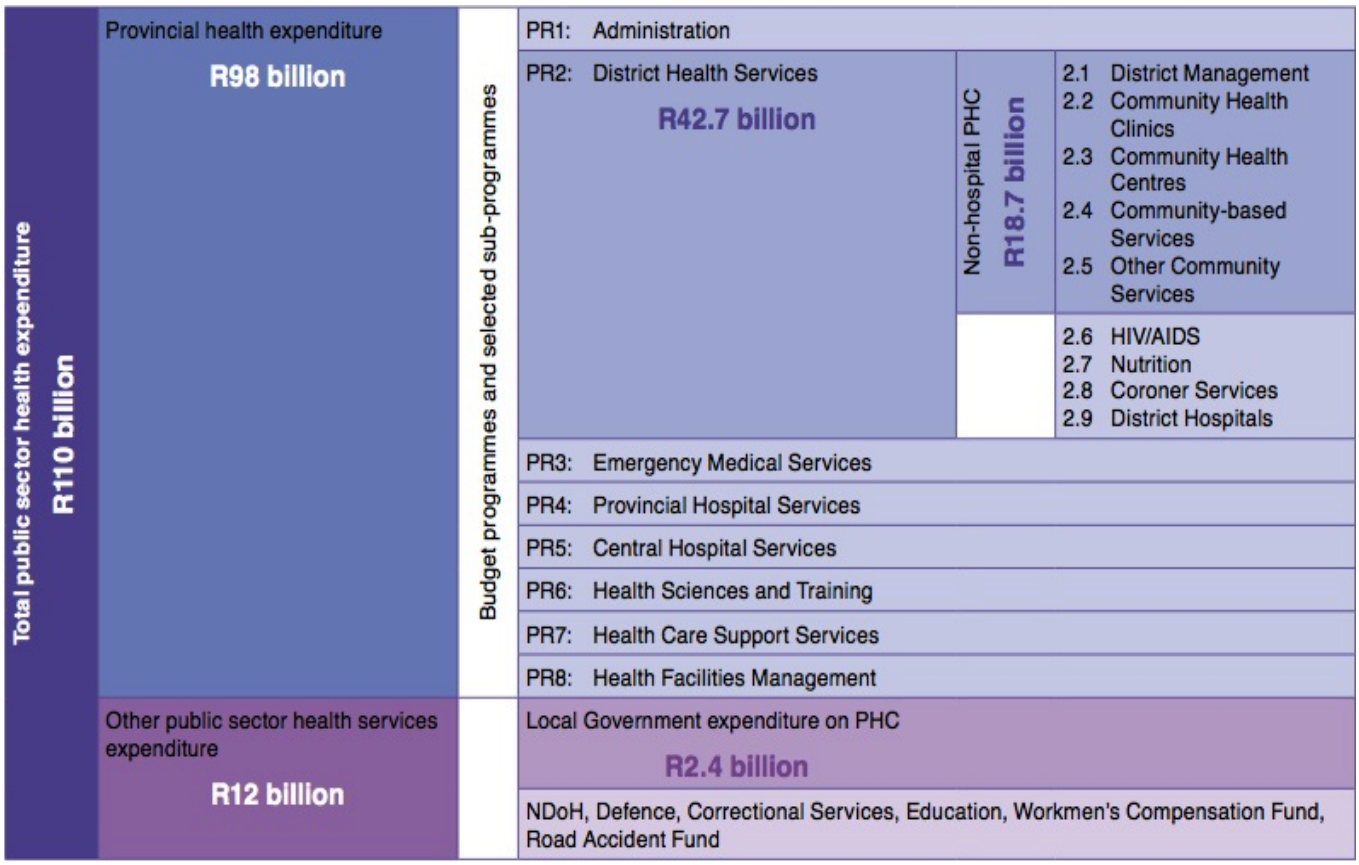

Total public sector health expenditure
R110 billion
Provincial health expenditure
R98 billion
Other public sector health services expenditure
R12 billion
Budget programmes and selected sub-programmes
PR1: Administration
PR2: District Health Services
R42.7 billion
Non-hospital PHC
R18.7 billion
2.1 District Management
2.2 Community Health Clinics
2.3 Community Health Centres
2.4 Community-based Services
2.5 Other Community Services
2.6 HIV/AIDS
2.7 Nutrition
2.8 Coroner Services
2.9 District Hospitals
PR3: Emergency Medical Services
PR4: Provincial Hospital Services
PR5: Central Hospital Services
PR6: Health Sciences and Training
PR7: Health Care Support Services
PR8: Health Facilities Management
Local Government expenditure on PHC
R2.4 billion
NDoH, Defence, Correctional Services, Education, Workmen's Compensation Fund, Road Accident Fund

Figure 2.

Programmes		Sub-programmes		Main items of expenditure
PR1	Administration			
PR2	District Health Services	2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9	District Management Community Health Clinics Community Health Centres Community-based Services Other Community Services HIV/AIDS Nutrition Coroner Services District Hospitals	Small amount of capital expenditure on transport and machinery & equipment Most expenditure on 'Goods and services: Recurrent expenditure' including: Compensation of employees (staff) Staff benefits, training, subsistence Agency staff Blood and clinical supplies Laboratory expenses Pharmaceuticals Other recurrent expenditure Transfers and subsidies to municipalities, agencies and staff benefits.
PR3	Emergency Medical Services			
PR4	Provincial Hospital Services			
PR5	Central Hospital Services			
PR6	Health Sciences and Training			
PR7	Health Care Support Services			
PR8	Health Facilities Management	8.1 8.2 8.3 8.4 8.5 8.6	Community Health Facilities Emergency Medical Rescue Services **District Hospital Services** Provincial Hospital Services Central Hospital Services Other Facilities	Capital expenditure on buildings, machinery and equipment Some expenditure on 'Goods and services: Other recurrent' – mostly on consultants/contractors

Since 2011, total government expenditure on healthcare has increase to R133.6 billion as of 2013 (National Treasury of South Africa, 2013). With regard to the national budget, "total PHC [primary health care] expenditure has nearly doubled in real terms from R27 billion in 2005/06 to R45 billion in 2010/11, much faster than the growth in the uninsured population (38.8 to 41.0 million). Total PHC expenditure per capita was R1,100 in 2010/11, having increased steadily from R666 in 2005/06" (Day et al. 2011, p. 1).

In addition to generalized spending, the national government also provides grants for specific projects. A list of grants and the money that is allotted for each of them is shown in the figure below (National Treasury of South Africa, 2012):

Figure 3.

R million	2011/12 Revised estimate	2012/13	2013/14	2014/15	Total for MTEF
Health	**23 877**	**25 692**	**28 750**	**31 794**	**86 235**
Comprehensive HIV and Aids	7 398	8 763	10 534	12 211	31 508
Forensic pathology services	590	–	–	–	–
Health infrastructure	1 690	1 621	1 721	1 836	5 179
Health professions training and development	1 977	2 076	2 190	2 322	6 588
Hospital revitalisation	4 172	4 104	4 184	4 556	12 844
National health insurance	–	150	350	500	1 000
National tertiary services	8 049	8 878	9 620	10 168	28 667
Nursing colleges and schools	–	100	150	200	450

Additional planned spending is also included in the treasury's review of 2012 and is shown in the table below (National Treasury of South Africa, 2012):

Figure 4.

R million	2012/13	2013/14	2014/15	Total
National health insurance pilot project	150	350	500	**1 000**
HIV and Aids and ARVs	–	–	968	**968**
Revitalisation of hospital infrastructure	–	132	294	**426**
Early childhood development	–	650	700	**1 350**

Provincial level (KwaZulu-Natal):

The *Forward by the Head of Department* at the beginning of the KwaZulu-Natal Annual Performance Plan (2011/12-2013/14) stated the following: "The main purpose for the existence of the Department of Health is to develop and implement a sustainable, coordinated, integrated

and comprehensive health system encompassing promotive, preventive, curative, rehabilitative and supportive/palliative care. This is guided by the principles of accessibility, equity, community participation, appropriate technology, and inter-governmental and inter-sectoral consultation and cooperation" (KwaZulu-Natal Department of Health, 2011).

The forward continued by stating the four main goals of the Health Department moving forward: The first is "Overhauling Provincial Health Services", which includes improvement of management, and reorganization of health services and PHC in particular. Another important aspect of this goal is to "eliminate bureaucracy" and to "decentralize delegations and accountability" (KwaZulu-Natal Department of Health, 2011). The second is "improving the efficiency and quality of health services" (KwaZulu-Natal Department of Health, 2011). In order to accomplish this, the Department of Health plans to strive towards the quality standards set at the national level, which will improve patient care, satisfaction, and safety. Lastly, this goal encompasses preparations for implementation of the NHI (KwaZulu-Natal Department of Health, 2011). The third goal is "reducing morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses", which includes the improvement of "maternal, child and women's health", improvement of HIV, TB, and malaria care and prevention, as well as improved treatment and screening for non-communicable diseases. The department aims to accomplish this goal through a "robust community-based strategy" (KwaZulu-Natal Department of Health, 2011). The fourth and final goal for the KZN department of health is "strengthening of inter-sector collaboration", which calls for increased cooperation between upper management and lower-level employees (KwaZulu-Natal Department of Health, 2011).

The department plans to allocate additional funding to "strengthen PHC management and service delivery" in order to aid the accomplishment of the goals set out above. Community health center and PHC clinics staffing structures have been changed and new positions have been added in an attempt to decrease "inefficiencies and duplication of services" (KwaZulu-Natal Department of Health, 2011). The *Forward by the Head of the Department* concludes: "health care is a significant and challenging area of government service. Despite fundamental constraints surrounding the recruitment and retention of critical and scarce skills and financial limitations, the future is a time for revitalization and honest assessment of current approaches, and our

willingness to consider new innovative and evidence-based approaches for service delivery" (KwaZulu-Natal Department of Health, 2011).

The following graph shows KZN health expenditure in previous years as well as predictions several years into the future (KwaZulu-Natal Department of Health, 2011).

Figure 5.

Programme R'000	Audited Outcomes			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Expenditure Estimates		
	2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
Administration (1)	279 730	284 066	1 048 878	313 717	349 621	327 503	344 171	364 189	381 119
District Health Services (2)	7 209 609	8 132 272	9 188 678	10 392 247	10 393 762	10 042 432	11 739 824	12 631 495	13 682 800
Emergency Medical Services (3)	548 796	672 360	782 332	866 383	865 188	867 271	926 747	999 262	1 056 911
Provincial Hospital Services (4)	3 883 814	4 378 814	5 071 290	5 549 184	5 736 592	5 853 243	6 366 182	6 863 490	7 199 701
Central Hospital Services (5)	1 407 703	1 821 221	2 059 135	2 144 817	2 278 470	2 218 427	2 473 982	2 742 023	2 940 700
Health Sciences and Training (6)	524 333	676 601	793 186	808 491	893 227	864 093	933 442	998 695	1 064 081
Health Care Support Services (7)	12 649	34 209	27 528	10 764	10 764	10 764	13 971	15 170	16 004
Health Facilities Management (8)	1 092 807	1 103 558	1 378 249	1 572 018	1 592 562	1 454 411	1 686 536	1 710 800	1 848 108
Sub-total	**14 959 441**	**17 103 101**	**20 349 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**
Direct charges against the National Revenue Fund									
Total	**14 959 441**	**17 103 101**	**20 349 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**
Unauthorised expenditure (1st charge)			**(758 000)**						
Change to 2011/12 budget estimate	**14 959 441**	**17 103 101**	**19 591 276**	**21 657 681**	**22 120 186**	**21 638 144**	**24 484 855**	**26 325 124**	**28 189 424**

The following figure gives a short summary of KZN health spending in 2013 (KwaZulu-Natal Department of Health, 2013):

Figure 6.

Programme	Total Appropriation	Actual Expenditure	Variance	% Spent	Factors that led to variances from Voted Funds, after considering the shifting and the virements of funds
	R'000	R'000	R'000		
Administration	439 238	449 603	(10 365)	102.40%	• The variance is mainly the result of acceleration in the fight against fraud and corruption as well as increased in audit fees.
District Health Services	12 002 952	11 993 168	9 784	99.99%	• The variance is mainly related to expenditure pressure related to HIV/Aids Conditional Grant for antiretroviral medication and micronutrients for the Grant.
Emergency Medical Service	955 850	955 048	802	100.10%	• The variance is related to delays with delivery of machinery and equipment: patient transport vehicles.
Provincial Hospital Services	7 831 188	7 887 054	(55 866)	100.70%	• The variance is related to pressures in goods and services mainly from the non-negotiable items: blood products, medicines - including MDR drugs, medical surgical supplies, X-Ray consumables, ambulance services (flying doctors) relate to fuel price increases, and repairs of medical equipment, municipal rates.
Central Hospital Services	2 732 692	2 764 028	(31 336)	101.10%	• The variance is the result of changes in dollar exchange relate for PPP contract (Inkosi Albert Luthuli Central Hospital).
Health Sciences and Training	930 733	930 793	(60)	100%	• The Department spent almost in line with the budgeted allocation.
Health Care Support Services	15 170	15 170	0	100%	• Spending is within the allocated transfer.
Health Facilities Management	2 383 107	2 395 669	(12 562)	100.50%	• The variance is the result of prior commitments for building and fixed structure and improved project management performance.
Total	**27 290 930**	**27 390 533**	**(99 603)**	**100.40%**	

Growth of per capita public spending on health care in KwaZulu-Natal seems to be lagging behind that of other provinces. "In 2008/09 [KwaZulu-Natal] had the highest total PHC expenditure per capita among provinces, but was ranked fourth lowest in 2010/11 with an expenditure unchanged since 2009/10 of R1,140" (Day et al. 2011, p. 202). "Along with the Free State, KwaZulu-Natal had the lowest non-hospital per capita expenditure on PHC in the country at R430 per person with a relatively low growth of 7.3% per annum between 2005/06 and 2010/11" (Day et al. 2011, p. 202). While this low spending could be caused by healthier citizens in the province, due to the relatively large burden of disease from HIV/AIDS and TB it seems more likely that the low spending is due to reallocation, or shortage, of government resources. "The percentage of district health services expenditure on district hospitals decreased

from 50.3% in 2009/10 to 47.4% in 2010/11, but remains above the national average of 39.8%. However, the proportion spent on district management (1.4%) is very low as compared to the national average of 5.4% and is the lowest in the country. Nine of the ten districts with the lowest proportion of their budget spent by district management are in KwaZulu-Natal" (Day et al. 2011, p. 202).

District Level (eThekwini):

As of April 16, 2013, the health goals for the district of eThekwini as stated by the health department of KwaZulu-Natal are the following (KwaZulu-Natal Department of Health, 2013):

1. Increasing life expectancy
2. Decrease maternal and child mortality
3. Combating HIV and AIDS and decreasing burden of disease from TB
4. Strength health system effectiveness
5. Combating non-communicable diseases

According to the 2012/13 District health Barometer presented by the Health Systems Trust, the district of eThekwini in 2012/13 spent 32.2% of the district health services expenditure on district hospitals, 66.5% on primary healthcare, and the remaining 1.3% on administration. In terms of percentage of total expenditure, only two districts in South Africa out of 52 spend less on administration than eThekwini (Health Sytems Trust, 2013). EThekwini is in the bottom half of spending on district hospitals with the average among the 52 districts at 37.5% of expenditure. Lastly, eThekwini ranks in the top half of primary healthcare expenditure with the national average among districts being 56.7% of expenditure (Health Sytems Trust, 2013). Per capita public healthcare expenditure in eThekwini was R1,125.3 in 2010/2011. Non-hospital PHC expenditure per capita was R500.1 in the same year.

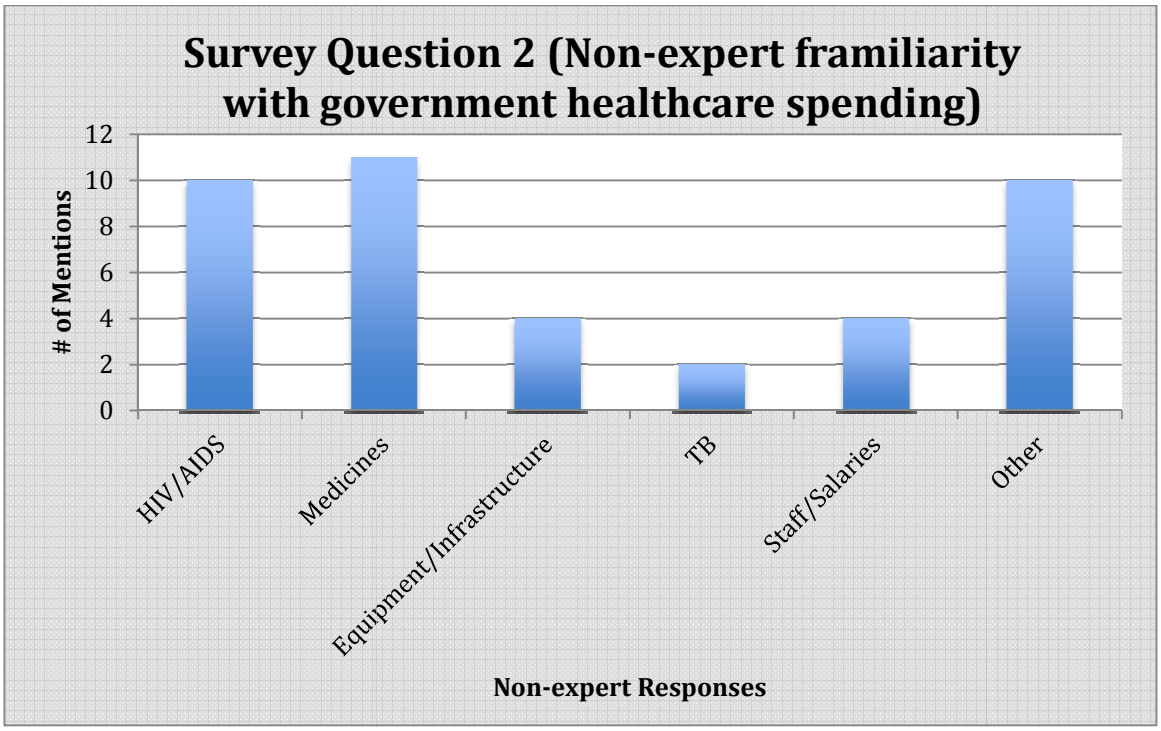
Non-experts

Survey question 2[4]: With which aspects of government healthcare spending were the participants familiar?

[4] Survey question 1 asked participants about previous, first hand experience with government healthcare. The data from question 1 is presented in appendix 4

The following graph describes the answers of participants when asked the question: On what is the government currently spending its healthcare budget? In other words, on what projects and/or goals is the government currently spending money? A total of 41 unique responses were recorded from the 29 non-expert participants who answered the question. 7 out of the 29 participants were unable to name any item on which the government was spending money. 16 participants gave either 1 or 2 unique answers while only 6 participants were able to proving 3 or more unique responses with 4 responses being the maximum from a single participant. The "other" category indicates answers that were not repeated. These include: contraceptives, paying for homes, providing food, corruption, home visits, family planning, abortion, general development, children's health, and finding a cure for HIV.

Figure 7.



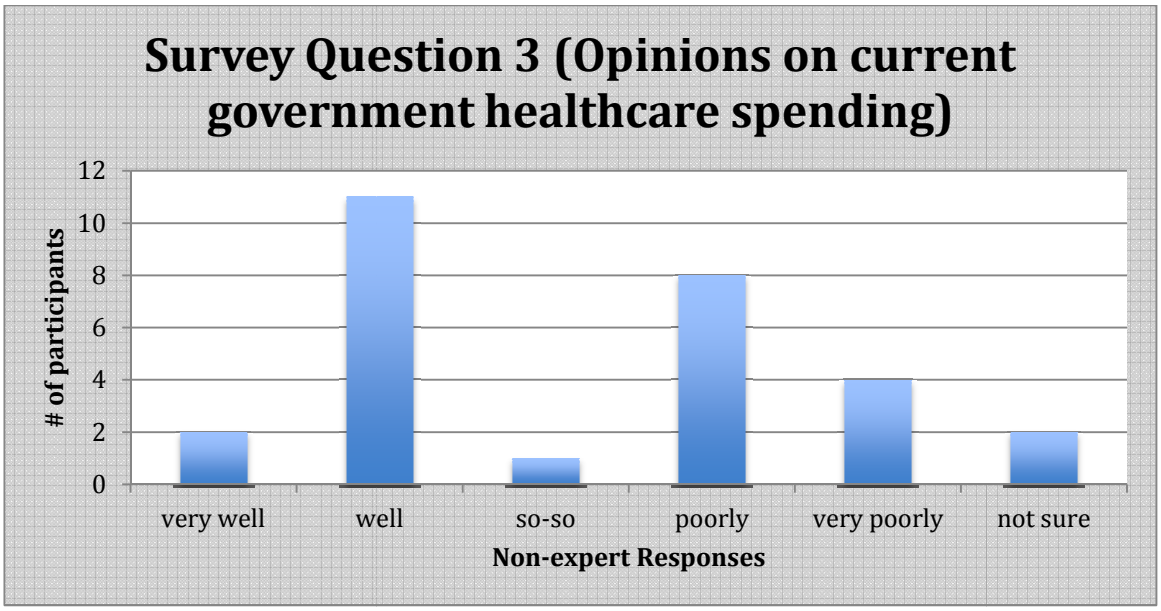
The government spends money on each of the items mentioned, although paying for homes as well as paying for food outside of hospitals is not considered within the healthcare budget. However, it is certainly valuable for the health of those receiving the benefits. The category of HIV/AIDS (which includes answers concerning both the provision of ARVs (Anti-retrovirals) specifically and the provision of educational information), and the more general answer of medicines were the most common categories appearing in individual answers. This may be

because participants were giving responses based on personal experience or the experiences of family and friends rather than basing their answers on knowledge of government healthcare expenditure. Following this trend, most responses identified facility or district budget spending, rather than national or provincial spending. However, responses concerning HIV/AIDS as well as equipment/infrastructure are included in the category of conditional grants at the national level. There were relatively few responses about healthcare facility staff/salaries, which is, according to the government, the item on which the majority of the healthcare budget is eventually spent. Overall, there seems to be some consensus that the government is spending money providing care for those with HIV/AIDS as well as providing necessary medication, as these two answers made up approximately half of the responses (21 of 41). However, there were a large number of unique responses (15), indicating significant diversity of knowledge among non-experts concerning government healthcare expenditure.

Survey question #3: What are the opinions of non-experts concerning the spending with which they are familiar?

Question 3 of the survey was intended to determine the opinions of participants regarding the spending of the healthcare budget. The graph below describes answers to the question: 'how well do you think the government is spending money allocated to healthcare? Is it very poorly, poorly, so-so, well, or very well?' Participants were asked to first give an answer on the provided scale and then to elaborate on the reasoning for that answer. A total of 28 responses are included in the figure below.

Figure 8



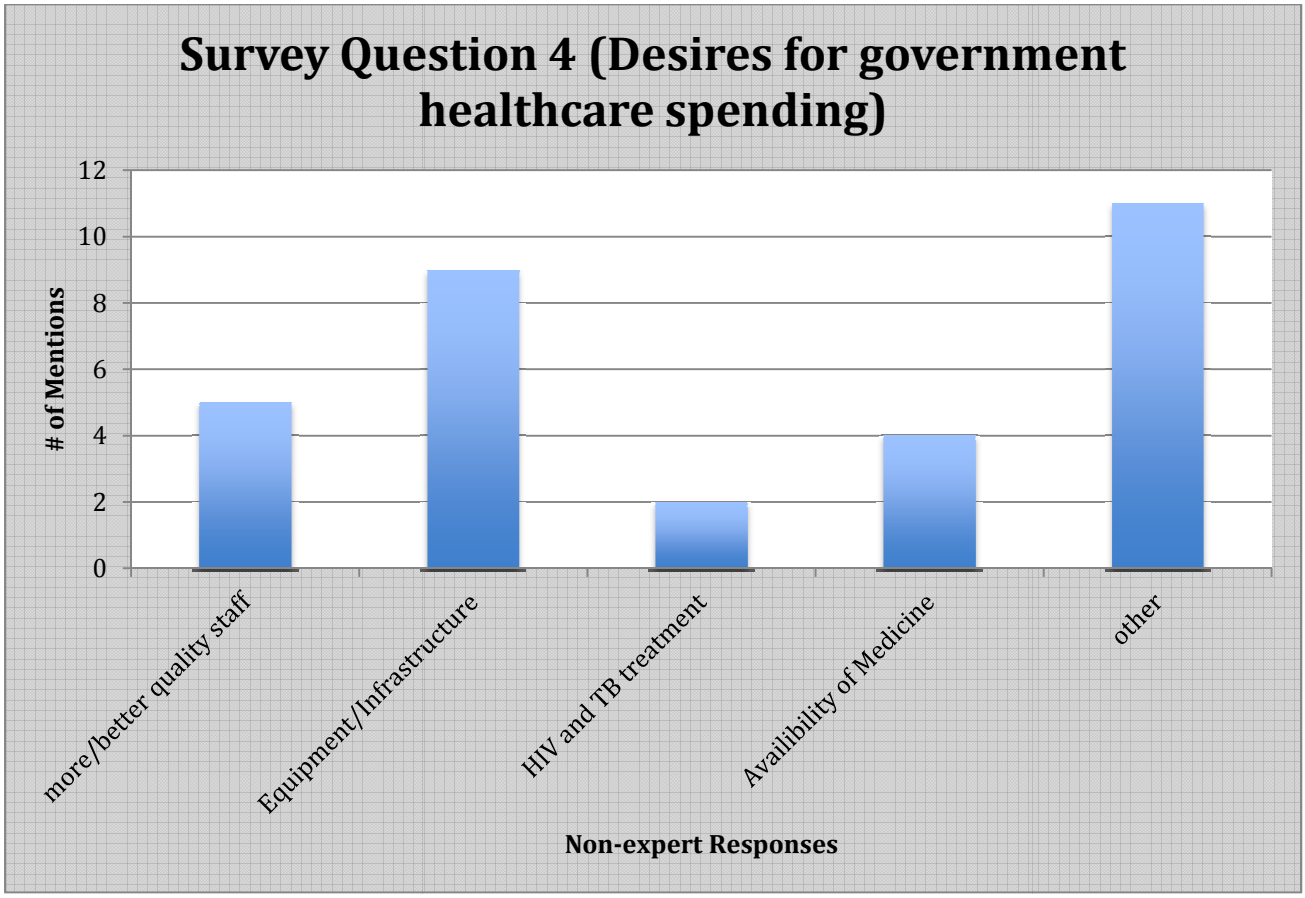
Among non-experts, there appears to be no consensus on the quality of healthcare budget spending. Although there were more participants that answered well then any other response, an almost identical number of participants indicated that the healthcare budget is poorly or very poorly spent (12) as indicated that it is well or very well spent (13). It is clear that participants were opinionated in either a positive or negative direction, as only 1 participant answered so-so. Medication was the focus for many of the individuals regardless of opinion. The provision of expensive medication was sited as a reason the government healthcare budget is well spent. However, multiple participants who thought that the budget is spent poorly or very poorly said that there is not enough medication and that clinics and hospitals often run out of stock. Other participants who think the budget is well spent sited the provision of necessary service by hospitals and the provision of services to the poor. One individual simply stated, "people are getting help" (participant 12, November 15, 2013). This same individual respected the government's effort to provide healthcare, especially given that government money must support other projects as well, such as education and housing (Participant 12, November 15, 2013). Another participant similarly stated of people that receive government healthcare that the government "provides them well" (Participant 24, November 18, 2013).

Survey Question #4: On what do non-experts think the government should be spending the healthcare budget?

Finally, to attempt to understand what participants want out of the government healthcare

system and in what directing they would like it to proceed, the following question was asked: How do you think the government should be using its healthcare budget? In other words, on what projects and goals should the government spend its healthcare budget? A total of 28 participants responded to this question, resulting in 31 answers. Five participants stated that they were unsure what the government should provide, while ten participants gave multiple answers. Figure 9 below describes the most common answers.

Figure 9.



Four general themes accounted for 20 of the 31 responses and were the only repeated answers. The remaining 11 answers were only state by one participant each. Two of the four

most repeated answers, better equipment/infrastructure, and improved HIV and TB treatment, are stated explicitly as currently goals of the government at the national and provincial, and district levels.[5] More/better quality staff is also a goal of the national and provincial governments, through training grants at the national level and through reorganization of management at the staff level. Lastly, better access to medicines is an implicit goal within the larger objective of providing accessible infrastructure such as hospitals and clinics to a larger portion of the population. Therefore, the most common areas in which participants would like to see improvement are already, at least theoretically, being address by government authorities. The desires of participants categorized as 'other' include the success of the NHI/standardization of care (2), girl/student pre-natal care (3), coverage of costly treatments such as cancer treatment (4), help for street children (6), increased research (11), increased awareness of local situations/issues (13), care for the poor (14), more widespread information on pregnancy and abortion (24, 25), and increased health information in rural areas (25). Lastly, two individuals stated that the way in which the healthcare budget is spent should not be changed (21, 22). Many of these improvements are implicit within the more general goal of increased accessibility to medical professionals through improved and newly created infrastructure. Others, such as the success of the NHI and standardization of care, are specifically stated goal of at least the national and KZN provincial Health Departments. Overall, the vast majority of health improvements that participants in this study would like to see are either explicitly or implicitly stated within the written goals of each of the three levels of government examined previously.

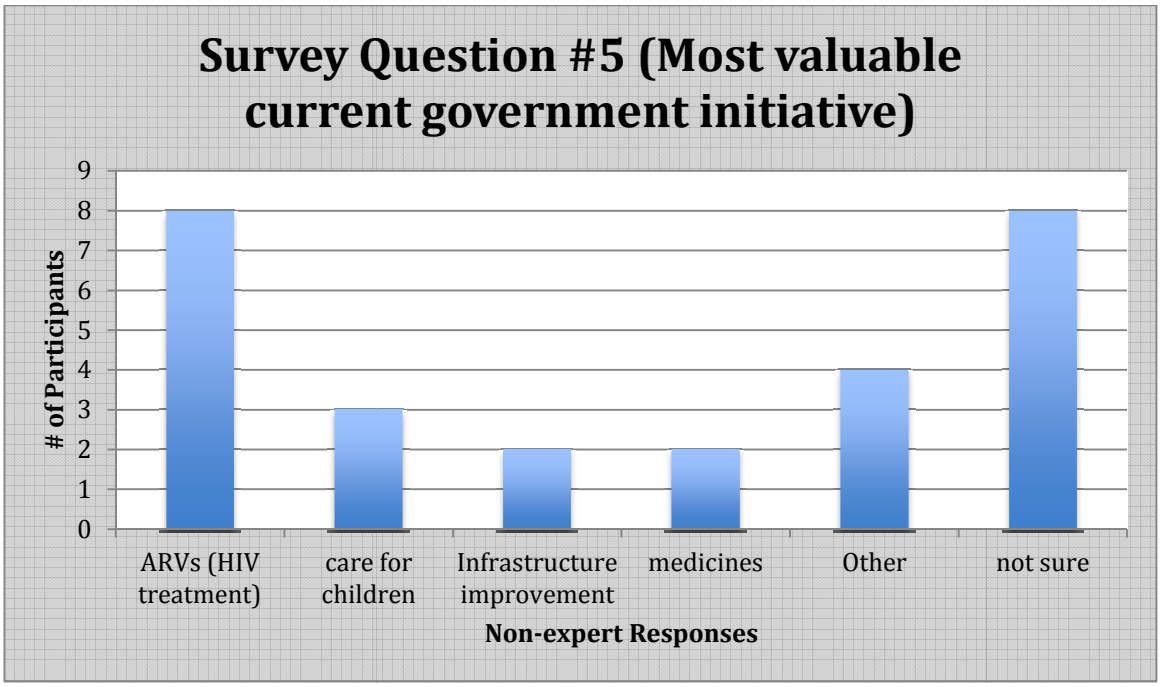
Survey question #5: What is the most valuable healthcare initiative currently funded by the Government?

To gain a better understanding about what aspects of the current government healthcare spending are desirable and undesirable, participants were asked the following two questions: What is the most valuable healthcare initiative the government is currently funding? What is the least valuable healthcare initiative the government is currently funding? One answer was recorded for each participant, resulting in 28 answers for each of the two questions. Where multiple answers were given, the first stated answer was recorded. The figure below present the data gathered for question 5, which asked about the most valuable healthcare initiative funded by

[5] See 'What the government is doing' section (figures 1-6)

the government.

Figure 10.



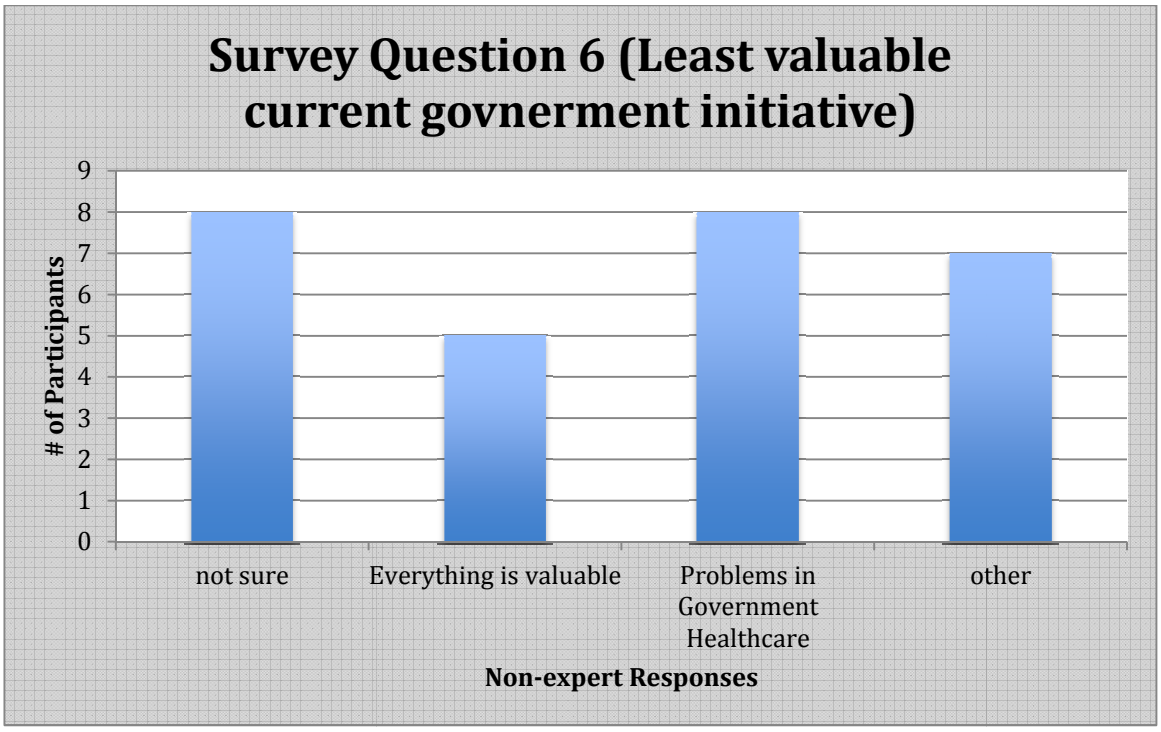
Anti-retroviral treatment was the most common answer, with more than double the number of participants citing it as the most valuable government initiative than any other initiative. Care for children, infrastructure improvement, and the general provision of medicines were the only other repeated answers (besides 'not sure'). Eight participants stated that they could not identify the most valuable current government initiative. Four participants gave responses that were not repeated (classified as 'other'). These included the provision of grants, the provision of houses,

hospitalization for the poor, and occasional good bedside manner. Each of the answers given for this question are healthcare initiatives provided by the government and the majority are given significant attention at multiple levels. As stated previously, the overarching government goals at the national, provincial, and district level includes the provision of ARVs to fight HIV/AIDS. Decreasing child mortality is also stated as a government goal at all three levels. Further, a major aspect of the national budget, as stated above in figure 3, is conditional grants. These grants include 'Comprehensive HIV and Aids', 'Health Infrastructure', and 'Hospital Revitalization' (National Treasury of South Africa, 2012). Also, there is already planned future spending on HIV/Aids, hospital infrastructure, and early childhood development at the national level as indicated by figure 4 (National Treasury of South Africa, 2012). Therefore, the government appears to be paying significant attention to those aspects of healthcare provision that are thought to be the most valuable by the participants in this study.

Survey question #6: What is the least valuable healthcare initiative currently funded by the Government?

The figure below describes the responses to question 6, which asked about the least valuable current government healthcare initiative. A total of 28 responses were gathered for this question, one per participant who answered the question.

Figure 11.



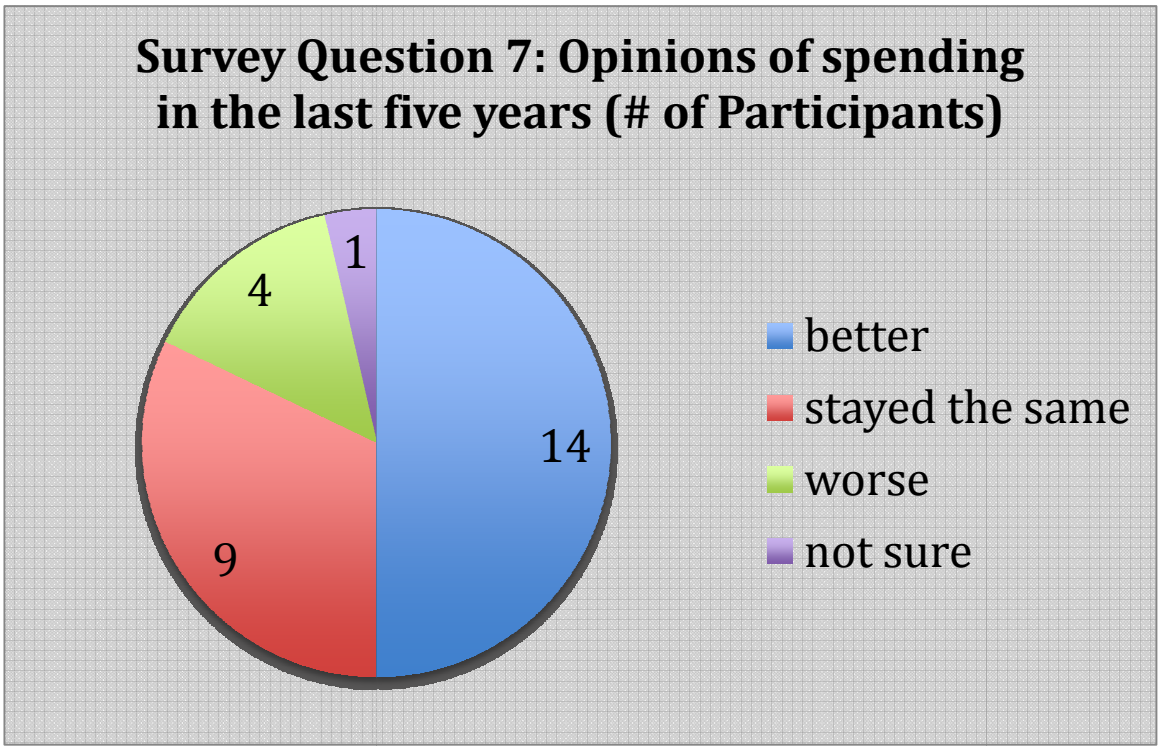
There were very few repeated answers to this question besides 'not sure' and 'everything is valuable'. The 'Problems in Government Healthcare' category delineates individuals who did not provide an answer delineating the least valuable initiative, but instead responded with an assessment of what is wrong with the government provision of healthcare. Answers in this category included long wait times (3 participants), not enough doctors and nurses (3 participants), that the government should provide ovarian cancer vaccines, and that facilities should not run out of ARVs. Participants in the 'other' category stated what they though was the least valuable government initiative. However, there was only one repeated response within this category, 'nothing is valuable' (2 participants). The remaining answers in the 'other' category were cancer treatment, malaria prevention/treatment, abortion/contraceptives, clinics for kids/pre-natal care, and corruption.

Survey question #7: In the past five years, has government-provided healthcare gotten better, worse, or stayed the same?

In order to understand the opinions of participants about the direction of government-provided healthcare more generally, two questions were asked, one concerning the past five years and one concerning the next five years. The first question was: In the past five years, do

you think government-provided healthcare has gotten better, worse, or stayed the same? One response was recorded for each of the 28 participants who were asked the question. The answers are presented in the figure below.

Figure 12.



Exactly half the participants answered that healthcare has gotten better in the past five years while only four participants thought that it has gotten worse. This indicates a generally positive feeling about the direction of government provided healthcare in the last five years. Many different reasons were given when participants were asked to elaborate on their answers. The most common reasoning among those who thought government provided healthcare has gotten better in the last five years was that accessibility has improved (participants 4, 13, 24, 25). One participant stated that some clinics are now open 24 hours a day where previously that had not been the case. Access to free healthcare (3, 21), infrastructure improvement (10, 13), and better HIV care (4, 23), each cited by two participants, were also given as reasons why government healthcare has improved in recent years. Four other areas of improvement were

cited by one participant each: the NHI (2), care for the severely ill (1), children's hospitals (1), and disease counseling (21). In relation to government spending, each of these improvements has been a focus of the government. These opinions show that, while not perfect, the government is making improvements in many target areas, and these improvements are significant to, and appreciated by, the participants of this study.

There was much less diversity in the reasoning of those who thought that government healthcare has stayed the same in the last five years. Four participants stated simply that the care provided by the government has not changed in recent years (5, 16, 18, 22). Only three other reasons were given as to why healthcare has stayed the same, each by only one participant. These were inadequate mediations (5), not enough equipment (5), and lack of effort and care from staff (6). Only one reason was repeated among the four participants who believe government provided healthcare has gotten worse in the last 5 years. Two participants cited lack of adequate doctors and other staff members (14, 29). Three other reasons were each mentioned once each, including long lines (29) and that treatment has become stagnant in the last 5 years and is not sufficiently dealing with the needs of the people (26). The last reason, as expressed by one participant, is that "people (employees) don't care anymore" (Participant 14, November 15, 2013).

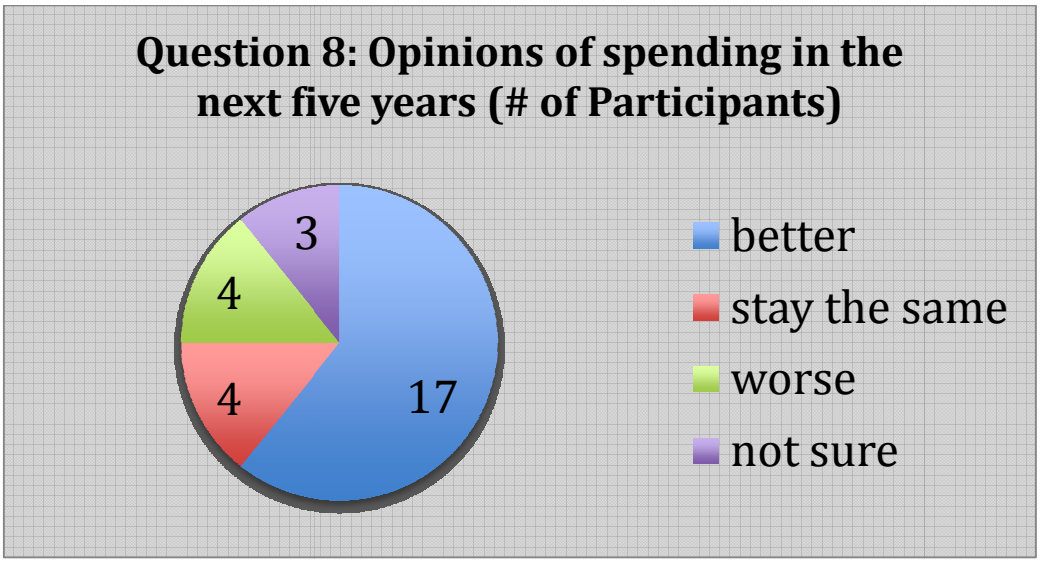
A pattern can be seen among those participants who feel as though healthcare has stayed the same or gotten worse in the last five years. Complaints focus mainly on the stagnation of provided services as well as on the inadequacy and general shortage of staff members. While the national, provincial, and district governments all aim, as indicated above, to provide better healthcare and broaden the scope of healthcare coverage, the majority of the current health initiatives aim to increase the coverage of government healthcare (through building and renovating infrastructure) and provide better care for specific needs groups (children, mothers, HIV infected individuals, and TB infected individuals) rather than being focused on providing more comprehensive care in general. Thus, the concerns of those who see no increase is services provided may not be addressed in the near future. The other most common concern among individuals who are unhappy with the current path of government-provided healthcare is staffing. However, the government is working on this issue in several ways at multiple different levels. At the national level, as shown in figures 1-3, the government is spending money training qualified staff through conditional grants. At the provincial level "improve[d] patient care,

satisfaction and safety" is included in the current goals. However, it is unclear whether sufficient money is being spent on this issue and whether these programs are significantly improving the current staff crisis.

Survey question #8: In the next five years, will government provided healthcare get better, worse, or stay the same?

The second of the two questions was: In the next five years, do you think government healthcare spending will get better, worse, or stay the same? There were also 28 responses recorded for this question, one per participant of whom it was asked. The responses to this question (question 8) are presented in the figure below (figure 12).

Figure 13.



More positive responses were received for this question than for question 7, with 17 participants indicating that they though government provided healthcare would improve in the next five years. Those who think it will improve again considerably outnumber those who think it will get worse, with only four participants taking the later view. The biggest change between questions 7 and 8 is the 'stay the same' category. While nine participants thought that government provided healthcare has stayed the same in the last five years, only four think it will remain the same in the next five years. A variety of reasons were cited by individuals who believed government healthcare will improve in the next five years, including several repeated answers. Three participants each cited the two most common answers. The first of these is general development (2, 9, 20). These individuals cited general economic growth and

technological improvement as a force that will improve government provided healthcare. This argument is well-founded because, as South Africa grows in wealth over time, its citizens and government will have more money and technology at their disposal, some of which will be used to increase the quality of healthcare. The second of the most common answers was that the improvement of infrastructure over time will create better healthcare (5, 9, 18). Three participants also cited upper management positions, two commenting that a new president would be good for government healthcare (13, 16) and one commenting that the current health minister is good for government healthcare (1). The other repeated answer, mentioned by two participants, was that rural areas are going to be provided with more health resources, such as medicines and health facilities, increasing the quality of healthcare in those areas specifically (15, 18). Finally, three other reasons were each mentioned once, including the improvement of HIV treatment (4), increased spread of health information (24), and the installment of the NHI (2). All of these improvements, besides a change in government officials and general economic growth, are current goals of the health departments at the provincial (KZN) and national levels.[6] Several of them are also goals of the eThekwini district as described above.

Among those who thought that government provided healthcare will stay the same in the next five years, the explanation was the same. Two participants said that as long as the current government is still in power, there will be no changes in government health (11, 17). Similarly, two of the participants who said that government provided healthcare will get worse in the next five years also cited the current government as the primary reason (14-19). Combining all answers, a total of eight participants cited government as a major factor in the future course of government healthcare. While there was great diversity among these six participants in terms of their view of the future of healthcare, a connection exists between all six answers: the current government is not doing the best job it could be doing, and a different government in the future would most likely improve the state of government healthcare. The only other answer cited as to why government healthcare will get worse in the next 5 years is that the treatment of patients by staff members is continuously deteriorating (8). Among those who were unsure about the future direction of government healthcare, only one justification was given, again reflecting the perceived importance of government officials at the highest level and of the upcoming election in 2014. These individuals, in contrast to those who think a new government would positively

[6] See 'What the government is doing' section (figures 1-6)

affect government healthcare, are unsure about the direction of healthcare under a new government.

Survey question 9: What is the NHI and what did non-experts think of its value to pubic healthcare/ability to be installed throughout South Africa?

Only seven of the 28 participants who were asked this question had heard of the NHI before. This is logical, given that the National Department of Health has not attempted to publicize the NHI initiative beyond government reports and documents that participants would not likely run across in the course of their day-to-day lives. All seven of those participant thought that the NHI would be valuable to pubic healthcare because it would allow all South African citizens to have access to free care, indicating that equality of service and universal coverage are important to those who participated in this study. Although few non-experts were knowledgeable about the NHI, it appears, from the responses of those who had heard of it before, that there is strong support for its continuation and eventual installment throughout South Africa.

Analysis of Experts:

Survey question 2: Do experts know how the government is spending its healthcare budget[7]?

As expected, expert participants were substantially more knowledgeable about government healthcare spending than were non-expert participants. The four experts interviewed most extensively (experts A, B, C, and F) were able to identify most of the main components of expenditure at each level. The two experts that were examined using only the non-expert survey (experts D and E) were able to identify fewer of the larger expenditure items, but did identify

[7] As with non-experts, the answers to question 1 can be found in appendix 4

several items that are at the center of focus of all levels of government[8]. At the national level, experts A, C, and F each directly identified the largest item of national expenditure given in figure 1, the provincial health expenditure. Each of these three participants identified the spending pattern of the national government, which included both the general expenditure given to provinces and at the local level for PHC as shown in figure 1 as well as the conditional grants shown in figure 3. Experts B, C, and F identified the more specific categories on which the national budget is eventually spent, such as infrastructure, medicines, and salaries. Experts D mentioned the government's focus on infrastructure as well as its attempts to increase human resources. Both of these are government priorities funded through both general expenditure and targeted grants. Lastly, expert E emphasized the treatment of HIV and TB, which has been and is currently a focal point at all levels of government healthcare provision. At the provincial level, experts A, B, C and F identified each of the four largest aspects of expenditure as shown in figure 6, made up by the funding of healthcare facility infrastructure and services. Experts A, B, C, and F were each able to identify the two largest items within the eThekwini district expenditure, PHC (funding of clinics) and district hospitals. Throughout the process of answering question 2, each of the experts repeated the largest aspects of expenditure that materialize at the facility level, including personnel salaries, medications, and equipment.

Survey question 3: How well do experts think the healthcare budget is being spent?

At the national level, there was disagreement among experts concerning how well the budget is spent. Two of the six experts thought positively about budget spending, one saying it is spent well (A[9]), while the other saying the money is spent at an above average level, but not quite well spent (C). In particular, expert A (November 8, 2013) thought that the conditional grants are valuable and was also impressed with the controlled increase in spending since the first democratic elections in 1994: "We've gone from nothing to quite significant expenditure in a fairly controlled way with evidence of changes in health statuses". On the other hand, three of

[8] Time constraints for these two experts prevented the researcher from using the full expert survey.

[9] Letters in parentheses at the end of sentences indicate the expert who held the previously described view.

the six thought that the money is either poorly spent (experts B and D) or very poorly spent (expert E). These experts expressed particular dissatisfaction with government healthcare management, pointing to corruption as a major source of weakness throughout all level of government. Expert B stated that there is poor management "throughout the system" pointing specifically to a lack of accountability and responsibility among management (November 8, 2013). He lamented that "there ought to be very good leadership, and that is one of the key issues; it boils down to poor management" (November 8, 2013). Expert D pointed to the lack of quality health education, leading to a dearth of qualified healthcare professionals (November 14, 2013). The last expert, expert F, answered so-so to the question of how well the healthcare budget is spent at a national level. His reasoning touched on the points made by all the previous experts: "I'm sure it could be [spent] more efficient[ly], but it's also clear that the welfare net now extends to something like 20 million people, [or] 40% of the population in a manner that didn't happen previously" (November 18, 2013).

At the provincial level, there was again no consensus. One expert, expert C, reflecting positively on healthcare spending, stated that the budget is spent in an above average manner, but not well. Two experts said it is spent poorly (B and F), while expert A stated that it is variable by province with the spending in KZN being about average. However, the majority of commentary on provincial spending was negative. Expert C (November 8, 2013) thought that "There are…political reasons why money is being spent rather than real, good evidence that it is being spent in the right way". Experts B and F site the lack of good management as a major problem, just as at the national level, with expert B again stating that there is a lack of responsibility and accountability. "There's so much expenditure that is unaccounted for" (Expert F, November 18, 2013).

There was again no consensus among experts at the district level, with one expert saying money is well spent (C), one saying it is poorly spent (B), one saying it is spent 'so-so' (F), and the final expert saying that it is variable by district (A). Expert A supported this claim by saying that funding is usually better spent in the urban districts and poorly spent in the rural districts (November 8, 2013). Each of the other experts had unrelated reasons to support their differing positions. Expert C thought that the district budget is well spent because there is more focus on preventative care at the district level as compared to the national and provincial levels (November 8, 2013). Expert F thought district healthcare spending is so-so because, while

districts do not yet deliver all the services that would ideally be provided, district officials and managers have been able to maintain facilities and even expand services slightly in the recent past despite the large increase in demand (November 18, 2013). Lastly, expert B believes that the district health budget is poorly spent for the same reason it is poorly spent at the national and provincial level, the lack of accountability and responsibility among leaders, saying that "it boils down to poor management" (November 8, 2013).

Finally, experts had much the same feelings about spending at the facility level as they did about spending at the district level, although admitted that it is much harder to grade on a scale due to the large number of facilities and variety of success within those facilities. Experts A and F felt uncomfortable giving a grade to the facility level as a whole, although they had contrasting comments about their experience with facilities that highlight the diversity of spending efficiency. Expert A stated that, at the facility level, "Control over expenditure and budget is really problematic because the systems aren't well organized" (November 8, 2013), while expert F, drawing on first hand knowledge, stated that "The facility that I know best, which is [in Pietermaritzburg]...seems to do a reasonably capable job from what I've seen" (November 18, 2013). Expert C had the same reasoning as at the district level, stating that facility budgets are well spend because they are more focused on preventative care than at the national or provincial levels (November 18, 2013). Expert B also had the same reasoning for his assessment that money is poorly spent at the facility level: there is no responsibility or accountability among those running the facilities. He stated that this problem "is endemic throughout the [healthcare] system" (November 8, 2013).

Survey Question 4: How should the government be using its healthcare budget?

National level:

When asked how the national healthcare budget should be spent, two major themes emerged, management and lack of spending on preventative care. The first is best described by expert F, who stated that he does not "have any qualms about the general direction of public health and the manner in which it is planned. The issue is more the execution" (November 18, 2013). Experts A and B shed some light on how to approach solving these issues. Expert A stated, "The biggest challenge at a national level is to regain a greater level of control over the provinces". He continued, saying that it might be valuable for healthcare officials to "Relook at fiscal federalism and decide whether that really is giving us the best control" (November 8,

2013). Expert B focused more specifically on the abilities and actions of healthcare leaders at the national level. One of the main problems, in his opinion, is that the high turnover at the health minister position makes focus on, and completion of, long-term tasks very difficult (November 8, 2013). He went on, stating that there are two important aspects of management at the highest level that are not currently present: "You need to have a very focused vision, and that vision should allow you to set your goals very clearly on what you want to achieve. You should then implement those goals and have people who are responsible and accountable [managing the system]" (November 8, 2013).

The other major theme, increased spending on primary healthcare, was stated most strongly by expert C, who said, "We are not spending enough money on promotive and population health. I think that there is still a lot of emphasis on curative [care]…Take something like HIV/AIDS. By far the majority of money… being spent [on HIV/AIDS is] in curative services on anti-retroviral therapy and not enough [is] on prevention. And that applies across the board" (November 8, 2013). Lastly, both experts D and E mentioned lack of adequate training for health professionals as an issue that should be addressed. Expert E stated that there should be more health education "beginning from primary school level going though university level" (November 14, 2013). This would help both with the issues of upper level management, as managers would be better trained, and with the lack of medical staff in healthcare facilities.

Provincial level:

At the provincial level, experts also supported more preventative care, or "evidence based public health" (Expert C, November 8, 2013). The theme of organization and management was again evident despite the diversity of specific concerns. Both experts A and B focused on specific areas of concern within the governance of provincial healthcare. Expert A concentrated on the poor management infrastructure: "One of the biggest problems the provinces have had is a lack of investment in control system and IT infrastructure. Far too much is still being driven by paper-based systems where you'll never get efficient control…Asking managers to work without the tools just doesn't work" (November 8, 2013). Expert B focused on another area of management infrastructure that is creating difficulties: "A lot of the way in which the political

environment works is like everywhere else. You've got to have the right sound bites and you've got to make them at the right time. It's not about implementing a policy that will lead to transformation at the health basis" (November 8, 2013).

District level:

According to experts, most of the same problems that exist at the national and provincial levels also exist at the district level. Thus, much of what experts would like to see happen with money at the district level is the management/organizational changes that were described above. Expert A stated that, while the system is supposed to run bottom up, with the districts requesting a specific budget allocation based on local needs, the system in fact works the other way around; the provinces allot money to districts based on their assessment of the district's needs. According to expert A, this problem needs to be solved either by a change in mindset that would allow the system to function as intended, or a complete organization change to establish an efficient top down system (November 18, 2013). Regardless of the system, expert F thinks "There should be better coordination between provincial and local [governments]. In many ways that would make organization even more difficult, but in terms of health I think it makes sense to do that. I suspect that a lot of local facilities are not used as effectively as they could be" (November 8, 2013). The repeated desire for increased preventative care was also present at the district level. Experts, however, also answered with two other specific concerns at the district level, the lack of dedicated and trained employees, and, tied to primary care, the lack of outreach to the community. The first of these, connected with a lack of quality infrastructure, was stated eloquently by expert B: "There are three things, one is [that] infrastructure is very often poor and not conducive to patients. The second thing is that there is a problem of greater demand then the services can provide. The third thing is that because of all of these frustrations the attitude of the healthcare givers is very poor" (November 8, 2013). The issue of community outreach was addressed by expert C, who stated that, "What [he] would like to see at the district level is…more community involvement. So more home-based care, [more] community care, [more] caregivers…There is a huge amount at that level, school health services, community based care, community health workers at a primary care level, that could be done" (November 8, 2013). He continued, tying the lack of outreach to the community with what expert B described as

frustrated and overworked healthcare employees: "The problem in health…is how do you motivate people to do what they should be doing" (November 8, 2013).

Facility Level:

The same problems stated for the three higher levels, management, lack of quality employees, lack of primary healthcare, and lack of preventative care, were all again concerns at the facility level. Expert B described what he thinks leaders must do in order for progress to be made at the facility level: "[They] have to start engaging…with government, with labor, with the unions, [and] with management. Our function is to deliver healthcare. How we are going to go about that and how we are going to come to an agreement to actually achieve that, and what do we need to put in place. You have to empower managers and allow them to actually manage like they would manage a private business" to provide accountability for workers. "You need to change the environment, you need to bring people into the social contract. In simple terms it means you've got to be more patriotic" (November 8, 2013).

Question 5: What is the most valuable healthcare initiative that the government is currently funding?

Experts were unanimous in response when the researcher asked question 5. Anti-retroviral treatment for HIV/AIDS was stated by each expert as the single most valuable government funded healthcare initiative. As describe by expert A: "Probably the [initiative] that has made the single biggest difference has been the anti-retroviral treatment program, because we've been able to document a change in life expectancy at birth, and that's pretty rare to not only show programmatic outputs but actual impact on health at a population level" (November 8, 2013). The NHI was also mention as a current initiative that, if successful, could substantially improve government healthcare throughout South Africa: "In principle, if we introduce the national health insurance that would be an amazing achievement because… it [would] achieve affordability and equity" (Expert B, November 8, 2013). Several other initiatives were also thought to be valuable by experts, including child immunization and provision of medicines, such as those for TB.

Question 6: What is the least valuable healthcare initiative that the government is currently

funding?

Although some initiatives were stated by experts as being less than ideal, the general feeling within each interview when the researcher posed this question is best described by expert F, who, when asked if there are any current government programs that are not particularly valuable, said, "No, I don't think so actually. Unfortunately I think the needs are so great that anything that [the government does] is probably going to benefit [people]. I think just in general it would be a matter of trying to ensure that there is less wasteful expenditure" (November 18, 2013). The idea that government initiatives are valuable, but that execution and management of these initiatives is poor, was again evident. Expert B stated this specifically about the NHI, saying that it is an extremely valuable initiative, but that the current strategy for implementation is destined to fail. Another initiative that fits this category, according to expert A, is NCDs: "Probably the area where we are not doing as well as we should is in screening for, identifying, and treating non-communicable diseases before people present and are already in trouble. I think NCDs would be the area where we are spending a lot of money but not making a lot of difference" (November 8, 2013). Other less-than-ideal initiatives mentioned by experts included lack of clarity in health policy, the district health specialist teams initiative, and the placement of some clinics and hospitals in rural areas.

Question 7: In the last 5 years, has government provided healthcare gotten better, worse, or stayed the same?

There was not a consensus among experts as to whether healthcare has improved in the recent past. Two experts stated that it has gotten better (C, F), one expert said it has gotten slightly better (D), two experts said that it has gotten worse (B, E), while the final experts stated that it is a mixed bag, some areas have gotten better, some have gotten worse, while others, such as KZN, have stayed the same (A). The reasoning of the three experts who though government provided healthcare had gotten better had similar reasoning. Both state that, overall, more people have greater access to a larger number of services than was the case 5 years ago: "The

differentials between the haves and the have-nots have gotten higher. But even those have-nots on the whole…are better off than they were before" (Expert C, November 8, 2013). Similarly, "The range of services has been extended and certainly more people have been brought into the healthcare net" (Expert E, November 18, 2013). The two experts who believed that healthcare has gotten worse sited the lack of quality leadership and the lack of trained personnel "It's basically because we just don't have the leadership, we don't have the accountability. There is a lot of waste in the system" (Expert B, November 8, 2013).

Question 8: In the next 5 years, will government healthcare get better, worse, or stay the same?

While experts were hesitant to predict the future of government healthcare, four of the six experts said that there were grounds for hope that it would improve, while the final two experts were pessimistic about the possibility of improvement. The four who thought that it is likely healthcare will improve all had similar reasoning; the current minister of health, Dr. Aaron Motsoaledi, is making the right moves and is a positive force: "I'd like to believe that it can get better. There's more attention, more money, and we've got an activist minister of health who doesn't take excuses" (Expert A, November 8, 2013). In the opinion of expert E, the health minister understands the complications of healthcare delivery at the lowers level because he is a doctor and therefore has experienced the trials of life in a healthcare facility (November 14, 2013). The experts who thought that healthcare may get worse in the next 5 years, on the other hand, think that the current course is not positive. "It is going to get worse unless we do something that changes the current course" (Expert B, November 8, 2013). Expert F agreed: "I think some of the easy gains have been made. Now it becomes a matter of accretion, trying to make incremental improvements and that simply depends on using resources better and having more skilled personnel" (November 18, 2013). The argument of expert F is logical, given that there is, at least according to the experts interviewed in this study, a lack of quality healthcare and management professionals.

Question 9: If the expert could change one thing in government provided healthcare, what would he/she change?

In answering this question, experts hit on each of the major themes from the questions

discussed above: management, accountability and responsibility among leaders, as well as preventative care. Expert B stated that, before anything else within the health sector can function well, "You have to have responsibility and you have to have accountability. We've got to get everybody working together with a common goal" (November 8, 2013). Experts D and F agreed. Expert D said he would "ensure…proper financial management" (November 8, 2013), while expert F stated, "[The] first issue would be far better financial control. You have got to free up these resources and use them more wisely. In the short term I wouldn't hire more doctors, I'd find some accountants" (November 18, 2013). Expert A, on the other hand, brought up a unique idea that sounds somewhat like the NHI initiative: "I would very aggressively look for opportunities to contract out services to private providers that are currently offered only through the state, but without reducing the investment in the infrastructure in the state sector. I'm not saying wholesale privatization, I'm saying where there is capacity that is underutilized in the private sector, and an overwhelming of state facilities, look for ways to unblock that and contract out" (November 8, 2013). This sounds much like the NHI concept of creating a public/private partnership in which the government pays for services within private facilities.

Question 10: What do experts think about the NHI in terms of its value to public healthcare as well as its ability to be established throughout South Africa?

All of the experts believed that the NHI is a positive thing for public healthcare. Expert B stated what appeared to be a consensus opinion among experts when he said: "If you have a National Health Insurance that addresses the questions of affordability, equity, and accessibility, that is without doubt the best thing that could ever happen to any healthcare system anywhere in the world" (November 8, 2013). In terms of its ability to be established there was again consensus that this would be an extremely challenging task. Many potential difficulties were mentioned, the most common of which was the requirement of a public-private partnership and the large quality gap that currently exists between the two. Expert C described the issue: "The public-private disparities are so huge and there's such entrenched resistance to NHI in the private sector. It's not going to be easy to raise the public sector to the level that is going to be acceptable for the private sector. [It's] going to be a huge mindset change to get them to contribute more to an NHI-like system" (November 8, 2013). However, there was still hope within the responses of the experts. Each expert seemed to believe that the government would

persist with the NHI until it is completed. Some predicted that it could take as long as 30 years to complete (more than double the 14 years suggested by current NHI plans), but would nevertheless be completed. According to expert F: "Assuming the African National Congress stays in power I'm sure it's something that they will persist with. It's going to be a process of muddling along as best as they can" (November 18, 2013).

Comparison between experts and non-experts

While there is a wide gap in terms of knowledge between experts and non-experts, many of the complaints and desires stated by non-experts are connected to the more complex issues voiced by expert participants. The difference between experts and non-experts was most clear in question 2, where experts were able to list many more of the high cost expenses included in government health expenditure. While most non-experts were able to list some items of government expenditure, experts were able to identify the top several items of expenditure at each level and had an in depth understanding of the interactions between levels of government. For open ended questions, it seemed as though non-experts were relying on personal experience with health facilities, stating aspects of expenditure such as medication and HIV treatment that they, or someone they know, has received from the government. On the other hand, experts drew on their education and research experience for more accurate answers that would be less obvious to individuals without years of education and experience in teaching and other professional fields.

Other than variances caused by difference in knowledge level, there were few other disparities between expert and non-expert responses. For questions 3, 6, and 7, expert and non-expert answers were similar. Both groups were mixed in opinion when asked how well the government is currently spending its healthcare budget. Most individuals in both groups either thought that there was a positive change or no change in the quality in government healthcare in the last 5 years, but thought that government healthcare will improve in the next 5 years

Demographic trends

Gender:

In total, 11 men and 26 women were interviewed within the non-expert group. Given the small sample size of men in particular, further study would be required to prove any gender-

based trends in opinions on healthcare. All in all, very few trends were observed between genders. Below are presented the analyses of each survey question by gender:

Question 1: No noteworthy trend was found between genders in question 1, which ask participants the last time they had received service from a government facility.
Questions 3, 7, and 8: These questions, asking about the current state of healthcare spending and enquiring about changes in the past 5 years, as well as predicted change in the next 5 years concerning the quality of healthcare, all showed no trends in terms of gender. Both men and women followed the overall trends found for all non-experts.
Questions 2, 4, and 5: These questions asked participants to identify what the government is doing, what the government should be doing, and to identify the most valuable government healthcare initiative respectively. While no gender trends were found for questions 4 and 5, question 2 suggested that men are more likely to cite infrastructure improvement as something the government is currently working on. Each gender group cited infrastructure 3 times, although many more women then men participated in the study. The reason for this trend is unclear, and further research would be required to ensure this result was more than simple coincidence.

Race:

Several trends existed within racial groups of participants in this study. While these trends would require a much larger sample size to substantiate, they are still worth mentioning. This study only included 3 White non-experts and 6 Indian non-experts. The remaining 20 non-expert participants were black. All notable racial trends are described below:

Question 1: Black participants were more likely to have used government healthcare services more recently than were either Indian or White participants.
Questions 3, 7, and 8: Among non-experts, white and indian participants universally stated that the healthcare budget is either poorly or very poorly spent. Conversely, only 4 of 20 black participants answered that the healthcare budget was spent poorly or very poorly. 13 of the black participants stated that the budget was spent either well, or very well, indicating that black participants may think more positively about government healthcare than do Whites and Indians.

However, this trend could also exist if Blacks are more supportive of the current government in general as compared to Whites and Indians. If this was the case, black participants may simply be showing their support for the government by supporting public healthcare efforts. It is also possible that the white an indian participants stated their displeasure with government healthcare due to their general dislike of the current government. In contrast to question 3, questions 7 and 8, asking whether healthcare has improved in the last 5 years and will improve in the next 5 years, did not show the same trends. The trend for each specific racial group was similar to that of all non-experts, indicating that no disparity exists between races.

Questions 2, 4, and 5:

The two questions (2 and 4) that asked individuals to name specific healthcare initiatives that were provided, or should be provided, by the government indicated that blacks were more likely than the other races to cite HIV/AIDS treatment. A possible explanation for this trend is that black participants were more likely to personally know another individual who was receiving ARV treatment from government facilities, making them more likely to think of ARVs as a government provided service and also more likely to consider this treatment a positive initiative. No other trends emerged within these questions.

Literature Review

Eriksson, M., & Linstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International, Vol. 23 No. 2* , 190-199.

- This article presents a succinct explanation of the River of Life as it applies to the Ottawa charter. The article, in part, considers the importance of preventative healthcare.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009, August 25). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet* , 817-834.

- This article provides a description of the history and organization of healthcare in South Africa. In particular, it focuses on the importance and influence of democracy in the South African healthcare system. It also presents several of the issues that have plagued the South African health system since the time of the first democratic elections, such as poor management.

Urbach, J. (2006). *South Africas chronic shortage of health care professionals.* Durban, South Africa: Health Systems Trust.

- This article form the health systems trust investigates the shortage of healthcare professionals in South Africa, comparing them to other developing countries. Specifically, the article considers why this is an issue within South Africa and explores potential strategies for addressing the problem.

Breier, M. (2008). *A multiple source identification and verification of scarce and critical skills in the South African labour market.* Pratoria: South African Department of Labor.

- This review by Breier first assesses the validity of the claim that there is a shortage of healthcare professionals in the labor market in South Africa. The author then examines the ways in which the South African government is attempting to address this shortage. Finally, the author looks at the future of both the supply and demand of health professional in South Africa.

Day, C., Barron, P., Massyn, N., Padarath, A., & English, R. (2012). *District Health Barometer.* Durban: Health Syestems Trust.

- The District Health Barometer, compiled by the Health Systems Trust, examines the health districts throughout South Africa, presenting and comparing their healthcare spending patterns. The article presented factual information about the spending patterns of the eThekwini district government.

Health Systems Trust. (2012, August 11). *Government prepares facilities ahead of NHI implementation.* Retrieved Novembe 26, 2013, from Health Systems Trust: http://www.hst.org.za/news/government-prepares-facilities-ahead-nhi-implementation

- This article presented the NHI as explained by minister of health. The article presented factual information about the NHI, including its basic features and implementation time frame.

Herbst, A., Cooke, G., Bärnighausen, T., KanyKany, A., Tanser, F., & Newella, M.-L. (2009). Adult mortality and antiretroviral treatment roll-out in rural KwaZulu-Natal, South Africa. *Bulletin of the World Health Organization* , 754–762.

- This journal article assessed the effect of ART within a specific community. It found that the treatment was effective, decreasing the mortality rate in the area. Lastly, it suggested the continuation and enlargement of the government ARV rollout.

Hirschowitz, R., Orkin, M., de Castro, J., Hirschowitz, S., Segel, K., & Taunyane, L. (1995). *A national household survey of health inequalities in South Africa.* Washington, D.C.: Henry J. Kaiser Family Foundation.

- This article presented the finding from a 1995 survey on healthcare inequality within South Africa, in which 4000 South African households participated. Part of the presented material included the perceptions of individuals concerning the quality of healthcare in South Africa.

Myburgh, N. G., Solanki, G. C., Smith, M. J., & Lalloo, R. (2005). Patient satisfaction with health care providers in South Africa: the influences of race and socioeconomic status. *International Journal for Quality in Healthcare* , 473-477

- This article examined a 1998 study involving 3820 households within South Africa. Part of the survey involved patient satisfaction with healthcare in South Africa. Specifically, the article looked at demographic trends within the satisfaction data.

Health Systems Trust. (2012, August 11). *Government prepares facilities ahead of NHI implementation.* Retrieved Novembe 26, 2013, from Health Systems Trust: http://www.hst.org.za/news/government-prepares-facilities-ahead-nhi-implementation

- This article presents the NHI as explained by the national minister of health.

KwaZulu-Natal Department of Health. (2013). *2012/2013 Annual Report.* Pietermaritzburg: KwaZulu-Natal Department of Health.

- This report presented the goals of the KZN Department of Health and commentary on those goals by upper management.

KwaZulu-Natal Department of Health. (2011). *Annual Performance Plan MTEF 2011/12 – 2013/14.* Pietermaritzburg: KwaZulu-Natal Department of Health.

- This annual report presents data on healthcare spending by the KZN Department of health. The report delineated both current spending and future planned spending.

KwaZulu-Natal Department of Health. (2013). *eThekwini District Presentation.* pietermaritzburg: KwaZulu-Natal Department of Health.

- This presentation gave details concerning the current healthcare goals and spending of the eThekwini district.

National Treasury of South Africa. (2012). *National Budget Review.* Pretoria: National Treasury of South Africa.

- The national budget review presented an en depth look at government spending in 2012 at the national level. The review showed the different aspects within healthcare spending, including transfers to provinces as well as conditional grants. It also presented planned future spending within healthcare.

Conclusions

There have undoubtedly been successes in the short life of government healthcare under a democratic government. According to both non-experts and experts interviewed in this study, the most prominent of these successes is the rollout of ARV therapy to combat the HIV epidemic. Secondary sources also agree that the rollout of ARV was an enormous success, paralleled by few other single initiatives: "Overall population mortality and HIV-related adult mortality declined significantly following ART roll-out in a community with a high prevalence of HIV infection. Not only does the decline [in mortality] show a temporal correspondence with the introduction of ART, but no other major health interventions were introduced in the study area during the same period" (Herbst, Cooke, Bärnighausen, KanyKany, Tanser, & Newella, 2009).

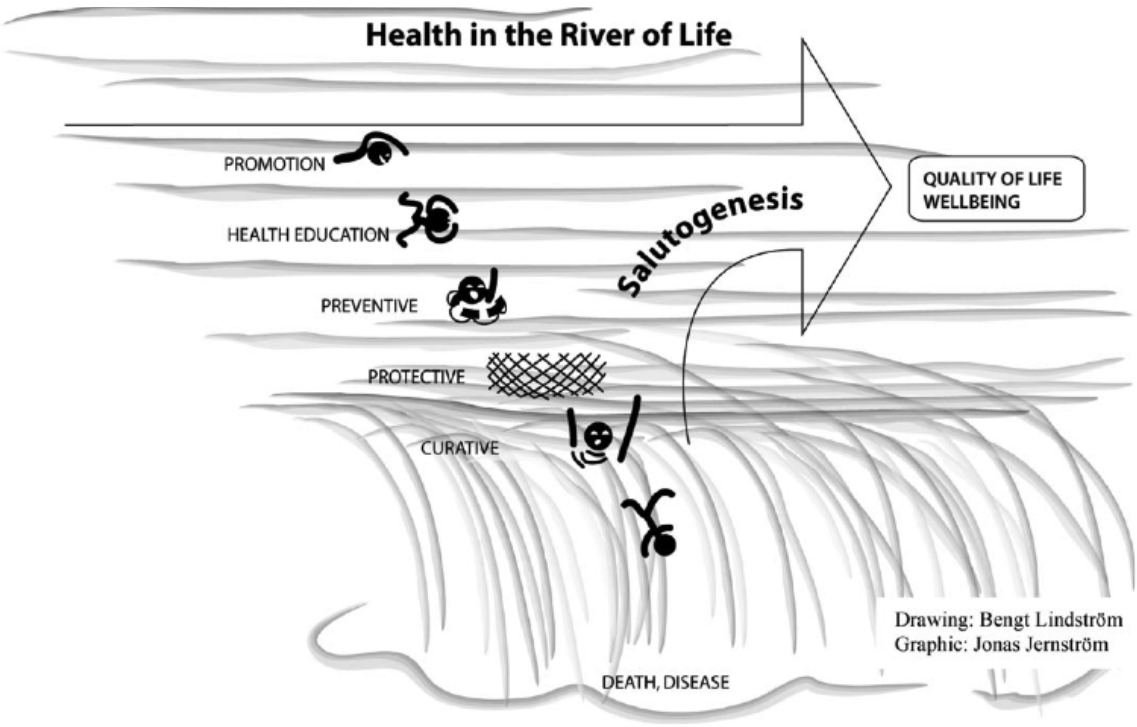
The testimony of participants also suggests that there are not many projects or initiatives on which the government is wasting money. While some experts and non-experts were able to cite programs they thought were inefficient or less valuable than desired, there was little repetition between answers, indicating that there are no ongoing, high budget programs systematically thought to be wasteful. None of the secondary sources the researcher read contradicted this finding or otherwise indicated that significantly wasteful programs exist, supporting the conclusion of study participants. This is also logical given the current state of South African healthcare as stated by expert F: "The needs are so great that anything that you do is probably going to benefit [people]" (November 18, 2013).

According to experts, quantity of money is not the issue holding back South African public healthcare: "We've got a lot of money. Money is not our problem, it's how we use it" (Expert B, November 8, 2013). What, then, are the pressing issues in the economics of healthcare in South Africa? According to experts, secondary sources, and non-experts, there are three main issues. These are the lack of investment in training, lack of investment in preventative healthcare, and, most importantly, poor management of the available funds. The first of the three appears to be evident to non-experts through the lack of trained doctors, and generally overworked, inexperienced healthcare workers. This issue was also explicitly described by several experts, who appeared to believe that the shortage of quality health workers would never improve if training were not prioritized. There is certainly a shortage of doctors, as confirmed by the South African Department of Labor: "data from a variety of sources indicate that there is indeed a shortage of doctors in South Africa in comparison with most other countries in the world, even

though we may seem to be well resourced in relation to our poverty-stricken neighbours in Africa" (Breier, 2008). Secondary sources, however, point to different causes of the shortage of doctors. According to Urbach, "[South Africa's] staff shortage is due in large part to unattractive working conditions within the public sector" (Urbach, 2006). While the explanation offered by Urbach will require more than a shift of funding by the department of health to solve, it is logical that if more doctors are trained, and the same percentage stay to practice in South Africa as do currently, there will be more doctors and other professionals working in the public sector overall.

The second of the three issues in the funding of healthcare given priority by participants in this study is the lack of preventative care. While not stated explicitly by non-experts, several pointed to increased health information as something that should be provided by the government in greater volume. Every expert explicitly pointed to preventative care as an important aspect of healthcare that is not currently provided adequate funding as stated in the above sections. The desire for increased preventative care was justified on the grounds that, as stated by expert B: "what you need to do is put a lot more effort into prevention of disease, so vaccination programs, the school health programs, have to be strengthened. Health promotion needs to be there so you are preventing the overload on the system at that level" (November 8, 2013). The logic is simple; the fewer people who get sick in the first place, the easier it is care for those who do get sick. This is beneficial for every aspect of government healthcare provision. The excess money that would no longer need to be spent providing treatment to the sick could be reallocated to infrastructure or training in order to provide higher quality healthcare. The concept of addressing healthcare issues at their source using preventative care rather than waiting for patients to get sick before treating them is not new. Health in the River of Life is a diagram (shown below) that presents the various levels of care. The argument being made by experts interviewed in this study is that the focus is currently on the curative level, and should move up the chain towards the protective and preventative care levels on a path towards, ideally, the health education and promotion levels.

Figure 14 (Eriksson & Linstrom, 2008).



While there is disagreement concerning current healthcare spending, some thinking it is spend well, while others thinking it is spent poorly, the majority of study participants come to the same conclusion that the future of public healthcare in South Africa is positive. Everyone agrees that the rollout of ARVs was monumental, and that this initiative should be continued into the future. There is also a consensus, especially among experts, that there should be an increase in preventative care to help lighten the patient load on a system that currently lacks the trained professionals required to treat the sick. While long-term solutions to this issue may exist, such as increasing the funding for training programs, other solutions must also be pursued. Although a lofty goal, the completing of the NHI might go a long way towards remedying these issues, and was very popular among experts and informed non-experts interviewed in this study. According to experts, this program would improve accessibility and equality in the government healthcare system, utilizing private facilities to absorb patients from over-crowded public facilities. If the trends from this study apply on a larger scale, and the NHI is a program that is popular among both experts and non-experts generally, then it should be aggressively pursued by the government until its completion.

The final, and most important issue in the economics of healthcare, according to study participants, is that of management. Before any of the above issues can be fully addressed or any

initiatives can be pursued with the expectation of full success, management within the government health system must be address. While both non-experts and experts only had positive comments about the current health minister, other answers concerning management were exclusively negative. Among non-experts, many cited the change in government as a deciding factor for the future of healthcare. No matter their belief concerning the future direction of healthcare, non-experts whose responses included comments on the government seemed to agree that a changing of the guard in leadership positions would be a positive turn for healthcare. Experts, while having more specific commentary, all agreed with the idea posited by non-experts; management needs to improve before other problems within the system can be addressed.

Several non-experts commented about the issue of corruption within the healthcare system, and, according to secondary sources, this is certainly a problem: A "key constraint is that at all levels of the health system there has been inadequate stewardship, leadership, and management. There is an increasing number of studies examining these deficiencies in different combinations both at different levels of the system and even between facilities of the same type" (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). "Accountability and responsibility" (Expert B, November 8, 2013) must be made integral to management at all levels. "We are quite good at coming up with good ideas [and initiating them], but we are not very good at…operation and maintenance" (Expert C, November 8, 2013). Everyone from leaders at the national level to staff members at the facility level must be accountable for their actions and have the drive and desire to address the massive health issues that confront South Africa. According to interviewed experts, if this mindset change happens, and, in the words of Expert B (November 8, 2013), healthcare workers are "more patriotic", then public healthcare has a great opportunity to be successful in providing health to all South African citizens.

What seems to be the overarching trend behind all these issues and suggestions for change is that South African public healthcare needs to focus on treating the causes of healthcare dilemmas in South Africa, rather than attempting to swim against the current, treating illness with a system that, in its current state, is lacking the resources to curb the tide of the disease burden South Africa is currently facing. While study participants strongly support the continuation of curative programs such as ARV treatment, it is through forward looking objectives such as preventative care and healthcare professional training programs that

participants appear to believe the highest level of healthcare can be achieved. The NHI, according to participants, would be a monumental step in the correct direction.

Recommendations for Further Study

To build upon this study, researchers in the future could design a study with a larger sample size in order to determine if the trends and presented opinions are accurate. Such a study could take place over a longer timeframe, using more interviewers. In this way, it could collect interviews from a larger area, not relying on convenience sampling as the researcher did in this study. This would allow the researchers to have demographic targets so that complex statistical analysis could be used to determine the relationships explored at the surface level in this study. A more in depth study with a larger sample size would help governments at each level to determine the healthcare initiatives that should be perused.

Future studies could also broaden the scope of analysis, looking at different demographics, such as age and years of education more closely. A valuable next step to gain a better understanding of the opinions of individuals may be to host focus groups that talk about government provided healthcare in terms what is already provided and what is expected from the government. Such focus groups would be valuable because they allow participants to flesh out their initial thought and ideas as well as add to the ideas of others. This would be a fascinating and valuable future ISP concept.

References

Urbach, J. (2006). *South Africas chronic shortage of health care professionals.* Durban, South Africa: Health Systems Trust.

Breier, M. (2008). *A multiple source identification and verification of scarce and critical skills in the South African labour market.* Pratoria: South African Department of Labor.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009, August 25). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet* , 817-834.

Eriksson, M., & Linstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International, Vol. 23 No. 2* , 190-199.

Day, C., Barron, P., Massyn, N., Padarath, A., & English, R. (2012). *District Health Barometer.* Durban: Health Syestems Trust.

(1978). *Declaration of Alma-Ata.* Alma-Ata, USSR.

Health Systems Trust. (2012, August 11). *Government prepares facilities ahead of NHI implementation.* Retrieved Novembe 26, 2013, from Health Systems Trust: http://www.hst.org.za/news/government-prepares-facilities-ahead-nhi-implementation

Health Sytems Trust. (2013). *District Health Barometer 2012/13.* Durban, South Africa: Health Systems Trust.

Herbst, A., Cooke, G., Bärnighausen, T., KanyKany, A., Tanser, F., & Newella, M.-L. (2009). Adult mortality and antiretroviral treatment roll-out in rural KwaZulu-Natal, South Africa. *Bulletin of the World Health Organization* , 754–762.

Hirschowitz, R., Orkin, M., de Castro, J., Hirschowitz, S., Segel, K., & Taunyane, L. (1995). *A national household survey of health inequalities in South Africa.* Washington, D.C.: Henry J. Kaiser Family Foundation.

KwaZulu-Natal Department of Health. (2013). *2012/2013 Annual Report.* Pietermaritzburg: KwaZulu-Natal Department of Health.

KwaZulu-Natal Department of Health. (2011). *Annual Performance Plan MTEF 2011/12 – 2013/14.* Pietermaritzburg: KwaZulu-Natal Department of Health.

KwaZulu-Natal Department of Health. (2013). *eThekwini District Presentation.* pietermaritzburg: KwaZulu-Natal Department of Health.

National Treasury of South Africa. (2013). *Budget 2013 highlights.* Pretoria: National Treasury.

National Treasury of South Africa. (2012). *National Budget Review.* Pretoria: National Treasury of South Africa.

Myburgh, N. G., Solanki, G. C., Smith, M. J., & Lalloo, R. (2005). Patient satisfaction with health care providers in South Africa: the influences of race and socioeconomic status. *International Journal for Quality in Healthcare* , 473-477.

(1986). *Ottawa Charter for Health Promotion.* Ottawa, Canada.

Puoane, T., Steyn, K., Bradshaw, D., Laubscher, R., Fourie, J., Lambert, V., et al. (2012). Obesity in South Africa: The South African Demographic and Health Survey. *Obesity* , 1038-1048.

South African Department of Health. (2013). *Indicators of Health Status and Health Care in SA.* South African Federal Government.

South African Department of Health. (2012, September 26). *Health*. (L. v. Niekerk, Editor) Retrieved September 22, 2013, from South African Government Information: http://www.info.gov.za/aboutsa/health.htm

Southafrica.info. (2012, July 2). *Health care in South Africa*. Retrieved November 23, 2013, from southafrica.info: http://www.southafrica.info/about/health/health.htm#structure

(1991). *Third International Conference on Health Promotion.* Sundsvall, Sweeden.

Tollman, S., Kahn, K., Sartorius, B., Collinson, M., Clark, S., & Garenne, M. (2008). Implications of mortality transition for primary health care in rural South Africa: a population-based surveillance study. *The Lancet* , 893–901.

List of Primary Sources

Anonymous. November 9, 2013, Cato Manor KwaZulu Natal: Young adult[10], Homestay brother within a Zulu household. The researcher lived with this participant for about a month, forming a close relationship.

Anonymous. November 9, 2013, Cato Manor KwaZulu Natal: Young adult, Second homestay brother of the researcher within a Zulu household. The researcher lived with this participant for about a month, forming a close relationship.

Anonymous. November 9, 2013, Cato Manor KwaZulu Natal: Middle-aged, Homestay mother of another student on the researcher's study abroad program.

Anonymous. November 9, 2013, Cato Manor KwaZulu Natal: Middle-aged, Homestay mother of the researcher for a period of about four weeks. The researcher formed a close relationship with this participant during the homestay experience.

Anonymous. November 9, 2013, Cato Manor KwaZulu Natal: Young Adult, Homestay brother of another student in the researcher's study abroad program.

Anonymous. November 11, 2013, Morningside, Durban KwaZulu-Natal: Middle-aged, Cold interview.

Anonymous. November 11, 2013, North Beach, Durban KwaZulu-Natal: Middle-aged, Cold interview

Anonymous. November 14, 2013, Public library in Chatsworth KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 14, 2013, Public library in Chatsworth KwaZulu-Natal: Middle-aged, Cold interview

Anonymous. November 14, 2013, Public library in Chatsworth KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 14, 2013, Public library in Chatsworth KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 15, 2013, Morningside, Durban KwaZulu-Natal: Young adult, Cold interview.

Anonymous. November 15, 2013, Morningside, Durban KwaZulu-Natal: Young adult, Cold interview.

Anonymous. November 15, 2013, Morningside, Durban KwaZulu-Natal: Young adult, Cold

[10] Individuals though to be between 20 and 30 years old will be designated as 'young adult'

interview.

Anonymous. November 11, 2013, North Beach, Durban KwaZulu-Natal: Middle-aged, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Middle-aged, Cold interview

Anonymous. November 16, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Middle-aged, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Young adult, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Middle-aged, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Middle-aged, Cold Interview

Anonymous. November 18, 2013, City Center, Durban KwaZulu-Natal: Middle-aged, Cold Interview

Expert A, November 8, 2013, University of KwaZulu-Natal – Medical School campus, Durban KwaZulu-Natal: Middle-aged, pre-scheduled interview through SIT connections.

Expert B, November 8, 2013, University of KwaZulu-Natal – Howard College campus, Durban KwaZulu-Natal: Middle-aged, pre-scheduled interview through SIT connections.

Expert C, November 8, 2013, Glenwood, Durban KwaZulu-Natal: Middle-aged, pre-scheduled interview through SIT connections.

Expert D, November 14, 2013, Chatsworth, KwaZulu-Natal: Middle-aged, pre-scheduled interview through SIT connections.

Expert E, November 14, 2013, North Beach, Durban KwaZulu-Natal: Middle-aged, pre-scheduled interview through snowball sampling.

Expert F, November 18, 2013, Pietermaritzburg KwaZulu-Natal: Middle-aged, pre-scheduled interview through SIT connections.

Appendices

Appendix 1: Survey Questions

Non-expert survey:

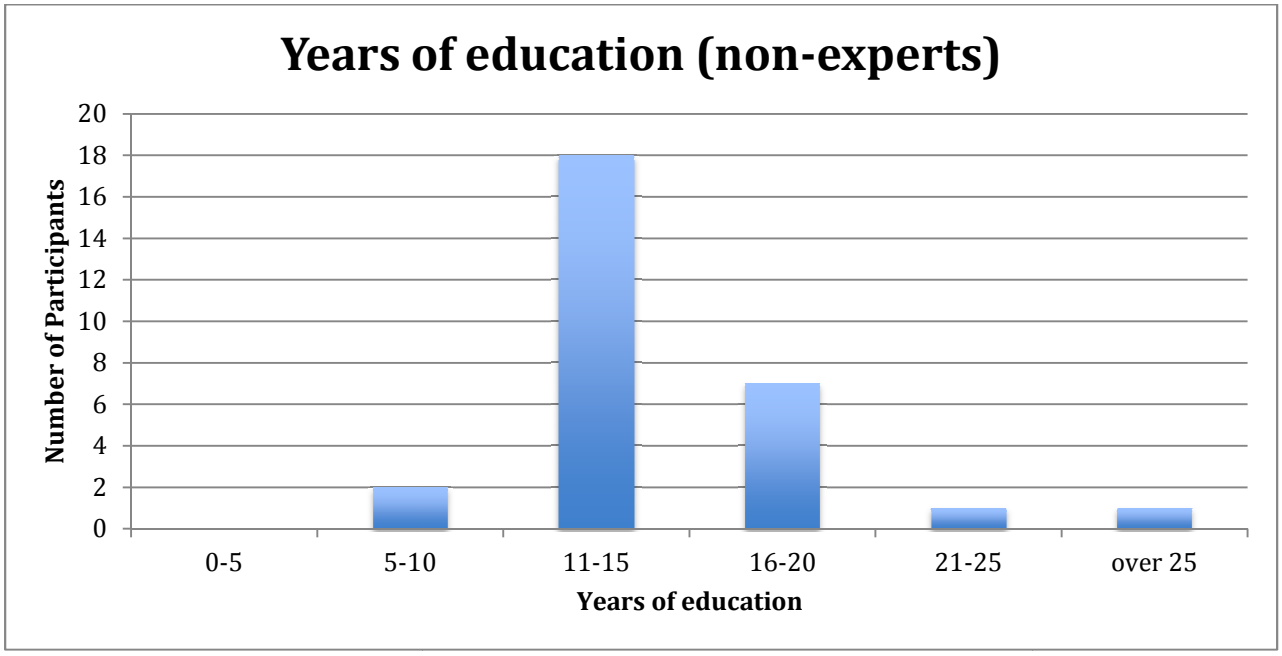
1. When was the last time that you, or someone in your family or someone close to you, used a government healthcare service of any kind?
2. On what is the government healthcare budget currently spent?
3. How well do you think the government is spending its healthcare budget? Is it very poorly, poorly, so-so, well, or very well?
4. On what should the government healthcare budget be spent?
5. What is the most valuable government healthcare initiative currently funded by the government at any level?
6. What is the least valuable government healthcare initiative currently funded by the government at any level?
7. In the last five years, has government provided healthcare gotten better, worse, or stayed the same?
8. In the next five years, do you think that government provided healthcare will become better, worse, or stay the same?
9. What is the NHI? What do you think about it in terms of it's value to public healthcare and its ability to be established throughout South Africa?

Participants were asked to explain their answers to each question.

Experts were asked to answer questions 2, 3, and 4 for each of the government levels analyzed in this study: national, provincial (KZN), district (eThekwini), and facility. Experts were also asked a tenth question, which was posed between questions 8 and 9 of the non-expert interview (and thus considered question 9 for experts): If you could change one thing about how the government is spending its healthcare budget, what would you change?

Appendix 2: Demographics

Figure 15.



The above figure presents the years of education of non-expert participants.

Expert years of education as givne by experts:

Expert A: 20 years

Expert B: 25 years

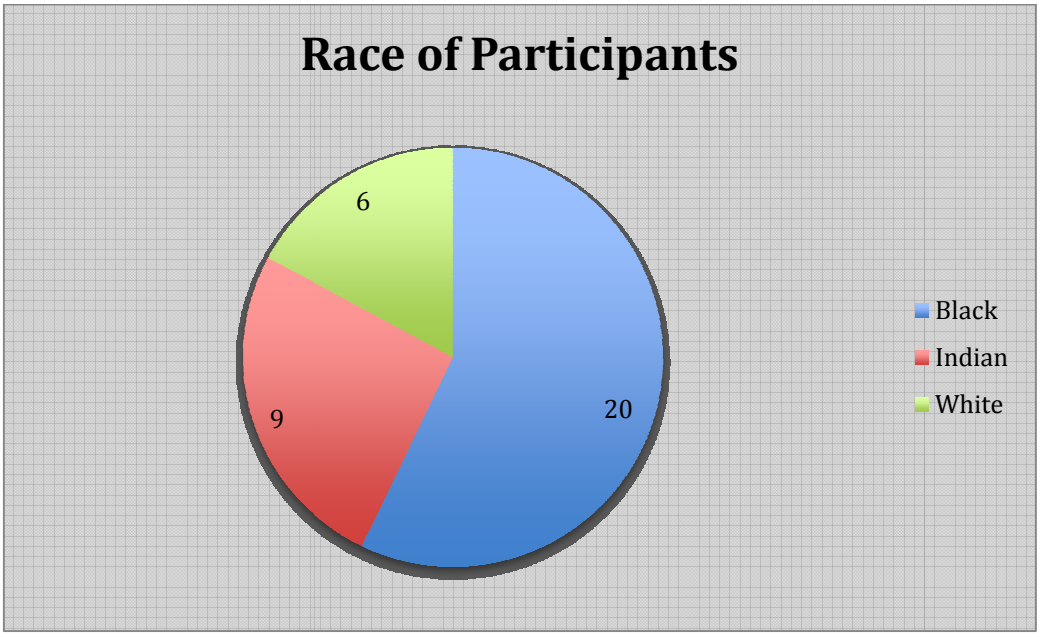
Expert C: 25 years

Expert D: 4 masters degree, 2 higher degrees (total years unknown)

Expert E: 21 years

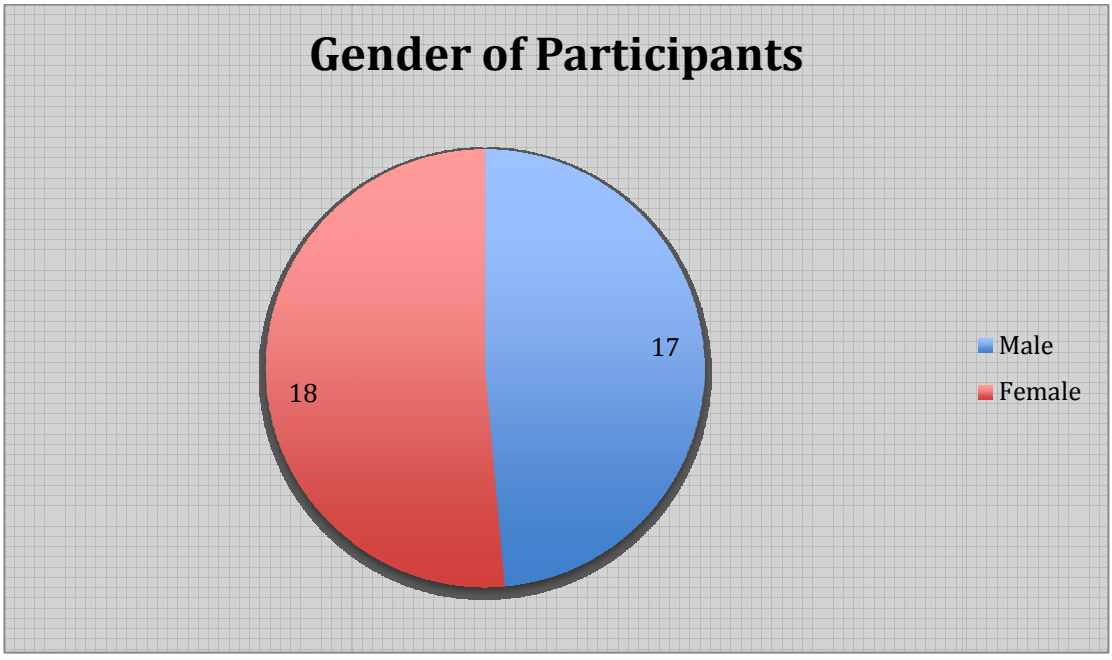
Expert F: 20 years

Figure 16.



The above figure presents the racial makeup of all participants in the study.

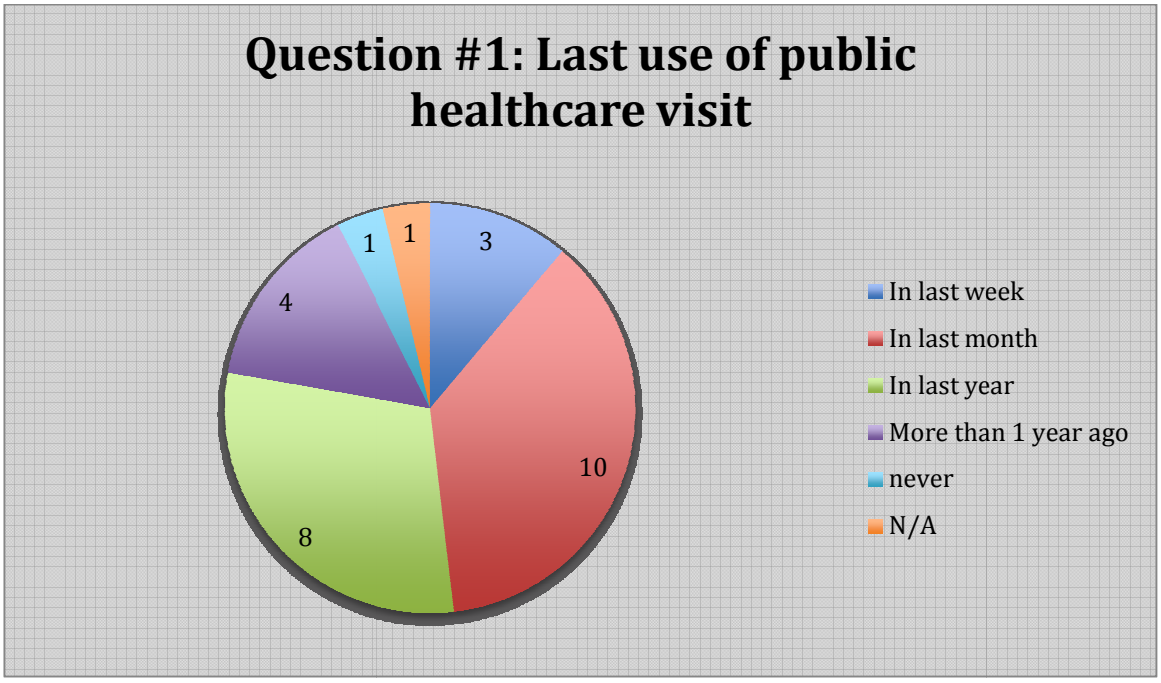
Figure 17.



The figure above describes shows the gender distribution of all participant in this study.

Appendix 3: Survey Question 1

Figure 18.



The figure above shows non-expert answers to question 1: When was the last time that you, or someone in your family or someone close to you, used a government healthcare service?

SIT Study Abroad
a program of World Learning

ISP Ethics Review

(Note: AD must complete this form for every student's ISP. A signed copy of this form must accompany any ISP selected as outstanding and sent to the Brattleboro office.)

This ISP paper by Alexander Braun (student) has

been reviewed by John McGladdery (Academic Director)

and does conform to the ethical standards of the local community and the

ethical and academic standards outlined in the SIT student and Faculty Handbooks.

Academic Director: John McGladdery
Signature:
Program: SFH Durban Community Health and Social Policy
Date: 30 November 2013